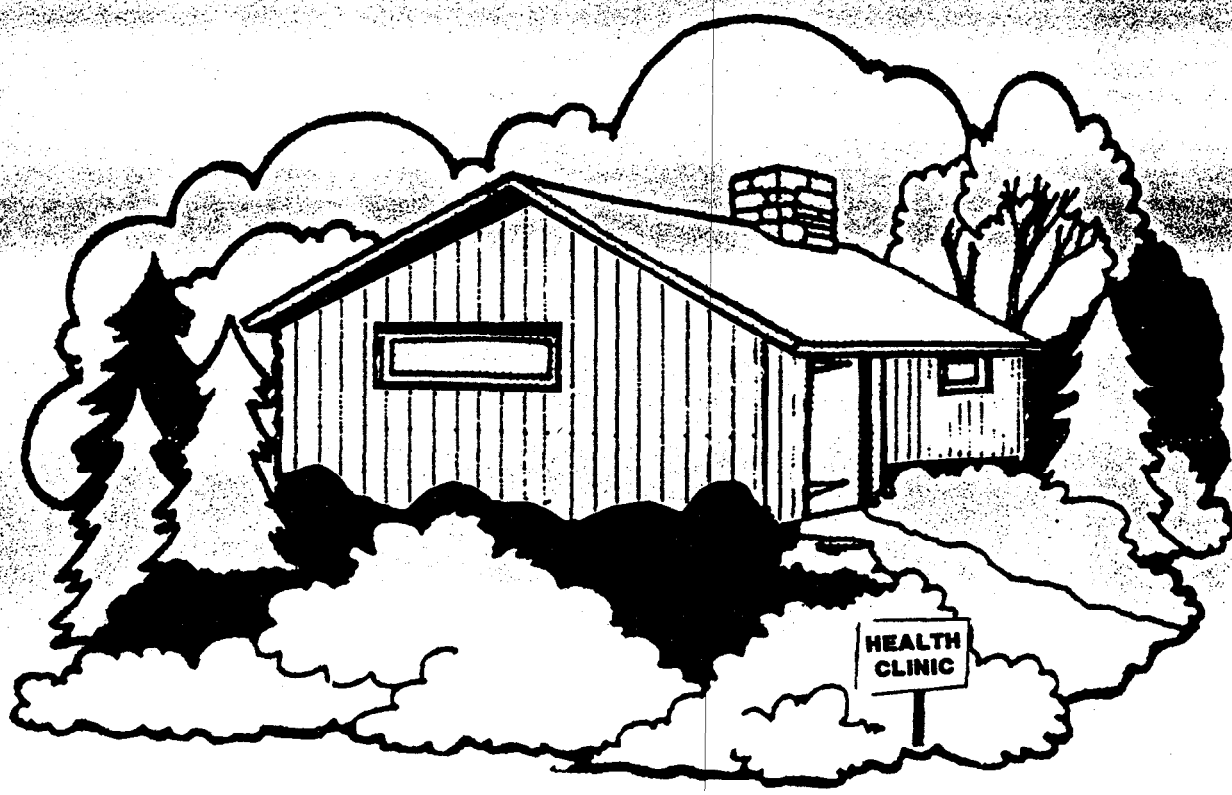
RURAL HEALTH CLINIC SERVICE MANUAL

Kentucky Medical Assistance Program
Rural Health Clinic Benefits
Policies and Procedures



Cabinet for Human Resources
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

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SECTION I - INTRODUCTION

I. INTRODUCTION

This new edition of the Kentucky Medical Assistance Program Rural Health Services Manual has been formulated with the intention of providing you, the provider with a useful tool for interpreting the procedures and policies of the Kentucky Medical Assistance Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will, hopefully, assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described fin this manual. Any questions concerning general agency policy should be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Division of Policy and Provider Services, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-6890. Questions concerning billing procedures or the specific status of claims should be directed to EDS, P.O. Box 2009, Frankfort, KY 40602, or Phone (800) 372-2921 or (502) 227-2525.

SECTION I - INTRODUCTION

B. Fiscal Agent

Effective December 1, 1983, Electronic Data Systems (EDS) began providing fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

II. KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

A. General

The Kentucky Medical Assistance Program, frequently referred to as the Medicaid Program, is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U. S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medical Assistance Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the Department for Medicaid Services is bound by both Federal and State statutes and regulations governing the administration of the State Plan. KMAP cannot reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered, unallowable medical services.

The Kentucky Medical Assistance Program, Title XIX, Medicaid, is not to be confused with Medicare. Medicare is a Federal program, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. The coverage, either by Medicare or Medicaid, will be specified in the body of this manual in Section IV.

B. Administrative Structure

The Department for Medicaid Services, Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. KMAP makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits which have been provided to eligible recipients.

Determination of the eligibility status of individuals and families for Medical Assistance benefits is a responsibility of the local Department for Social Insurance offices, located in each county of the state.

C. Advisory Council

The Kentucky Medical Assistance Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of seventeen members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining sixteen members are appointed by the Governor to four-year terms. Nine members represent the various professional groups providing services to Program recipients, and are appointed from a list of three nominees submitted by the applicable professional associations. The other seven members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five-member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is

decided by the professional organization that the technical advisory committee represents. The technical1 advisory committees provide for a broad professional representation to the Advisory Council.

As necessary, the Advisory Council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medical Assistance Program hereinafter referred to as KMAP, is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulates that Title XIX Programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medical Assistance Program has secondary liability. Accordingly, the provider of service should seek reimbursement from such third party groups for medical services provided. If you, as the provider, should receive payment from KMAP before knowing of the third party's liability, a refund of that payment amount should be made to KMAP, as the amount payable by KMAP shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers must agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap, or age.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

Each medical professional is given the choice of whether or not to participate in the KMAP. From those professionals who have chosen to participate, the recipient may choose the one from whom he/she wishes to receive his/her medical care.

When KMAP makes payment for a covered service and the provider accepts the payment made by KMAP in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient; or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and/or imprisonment.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

Medical records and any other information regarding payments claimed must be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection and/or copying by Cabinet personnel.

All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to recipients of this Program shall be on a level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.

All recipients of this Program are entitled to the same level of confidentiality accorded patients not eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical specialty.

All services are reviewed for recipient and provider abuse. Willful abuse by the provider may result in his or her suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he or she receives.

No claim may be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, no claims will be paid for services that required, but did not have, prior authorization by the Kentucky Medical Assistance Program.

No claims may be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and such payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to the Cabinet and no bill for the same service shall be paid by the Cabinet.

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services1 for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual 'and such other person.

(b)(l) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, ileasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever- knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

F. Timely Submission of Claims

In order to receive Federal Financial Participation, claims for covered services rendered eligible Title XIX recipients must be received by EDS within twelve (12) months from the date of service. Claims received after that date will not be payable. This policy became effective August 23, 1979.

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. History and Definition

The passage of the Rural Health Clinic Services Act of 1977 (Public Law 95-210) was intended to encourage the provision of medical care in rural, medically underserved areas by providing for Medicare and Medicaid reimbursement of a broad range of diagnostic and treatment services furnished in qualifying rural health clinics.

'The clinics, though physician directed, may be staffed by Advanced Registered Nurse Practitioners who are specially trained to provide general medical care.

B. Participation Requirements

1. To participate as a reimbursable health provider under the rural health services.element of the KMAP, each rural health clinic will be required to meet the standards established for licensure and be licensed by the Certificate of Need and Licensure Board in accordance with the requirements set forth in State Licensure Regulation 902 KAR 20:145 and be certified as a rural health clinic by Title XVIII.

2. Out-of-state rural health clinics applying for participation must be licensed by the appropriate agency of the state in which they are located, if applicable, and must meet Title XVIII certification standards.

3. Having met such requirements, a rural health clinic will be required to enter into a participation agreement with the Cabinet and will be issued a notification of participation. Such participation agreement may be nullified by the Cabinet with appropriate prior notice if at any time a rural health -clinic fails to meet a condition of participation or licensure.

   An application for participation shall include:

   a. Agreement for Participation (MAP-343).

   b. Provider Information Sheet (MAP-344).

   C. Statement of Services Provided.

   d. A list of staff of the rural health clinic and their respective license numbers; Certification of Conditions Met (MAP-346).

   e. A Statement of Authorization (MAP-347) for each licensed medical professional on the staff. Attach a copy of the license for each licensed professional on staff.

   f. A Statement terminating any existing agreements with other service elements of the KMAP.

4. The completed participation documents, signed by the administrator of the clinic; must be submitted to the Department for Medicaid Services and subsequently approved, prior to receiving reimbursement for services rendered eligible Program recipients. A provider number and the clinic's interim rate of payment will be included with the notification of participation approval by the Department for Medicaid Services.

5. Concurrent with the effective date of participation in the rural health clinic services element of the Program, the clinic will cease to submit billings to other elements of the KMAP for services rendered Title XIX recipients.

6. All physicians/dentists/other licensed professionals must have valid licenses to practice at the time medical services/ procedures are performed.

7. The physician/other licensed professional whose KMAP provider number is entered in Block #17 of the MAP-7 as the professional rendering the service must have patient contact for each service billed.

8. Medical Records: Medical records in the rural health clinic must substantiate the services billed to the KMAP. The medical records must be accurate and appropriate and entered personally or countersigned by the professional who rendered the service. All records must be signed and dated. Stamped signatures are not acceptable.

   The results of diagnostic testing, including negative test results, must be indicated in the medical record of the patient. The date of the test shall be the same date for which the KMAP is billed.

   Medical records must be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit exception or other dispute. The records and any other information regarding payments claimed must be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection and/or copying by Cabinet personnel.

9. The medical records of the patient in the hospital must document through signed or countersigned notes that the billing physician did one or more of the following:

   a) personally reviewed the patient's medical history;
   b) performed a physical examination;
   c) confirmed or revised the diagnosis;
   d) face-to-face encounter with the patient;
   e) discharged the patient.

C. Termination of Participation

907 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medical @Assistance Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;

3. Misrepresenting factors concerning a facility's qualifications as a provider;

4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or

5. Submitting false or questionable charges to the agency.

The Kentucky Medical Assistance Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

1. The reasons for the decision;

2. The effective date;

3. The extent of its applicability to participation in the Medical Assistance Program;

4. Theearliest date on which the Cabinet will accept a request for reinstatement;

5. The requirements and procedures for reinstatement; and

6. The appeal rights available to the excluded party.

The provider receiving such notice may request an evidentiary hearing. The request must be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence-shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;

2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;

3. Counsel representing the provider;

4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and

5. An. opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the Cabinet for Human Resources.

These procedures apply to any individual provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medical Assistance Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medical Assistance Program. Adverse action taken against an individual provider under Medicare must be appealed through Medicare procedures.

IV. SERVICES COVERED

The clinic is primarily engaged in providing outpatient health services to persons of all ages.

A. Rural Health Clinic Services (Title XVIII)

. 1. Basic Diagnostic and Therapeutic Services

Covered services and supplies incidental to treatment that are commonly furnished in a physician's office or at the entry point into the health care delivery system when provided by a physician or advanced registered nurse practitioner (including nurse midwife) include medical history, physical examination, assessment of health status, diagnosis and treatment for a variety of medical conditions for all age groups.

2. Basic Laboratory Services

The clinic must provide the following basic laboratory services essential to the immediate diagnosis and treatment of the patient:

a. Chemical examinations of urine by stick or tablet methods or both (including urine Ketones);

b. Microscopic examinations of urine sediment;

c. Hemoglobin or hematocrit;

d. Blood sugar (stick or tablet method acceptable);

e. Gram stain;

f. Examination of stool specimens for occult blood or pinworm;

g. Pregnancy tests and;

h. Primary culturing for transmittal to a certified laboratory.

3. Emergency

The clinic provides medical emergency procedures as a first response to common life-threatening injuries and acute illness, and has available the drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids.

4. Services provided through agreements or arrangements.

a. The clinic has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to its patients, including:

(1) Inpatient hospital care;

(2) Physician(s) services (whether furnished in the hospital, the office, the patient's home, a skilled nursing facility, or elsewhere); and

(3) Additional and specialized diagnostic and laboratory services that are not available at the clinic.

b. If the agreements are not in writing, there is evidence that patients referred by the clinic are being accepted and treated.

5. Visiting Nurses Services

Some visiting nurse services are covered if the rural health clinic has been designated and certified by Title XVIII to provide these services. Detailed information regarding this service, including procedure codes for billing purposes, is available as an addendum to this manual and will be sent to clinics certified by HCFA to provide this service.

SECTION IV - SERVICES COVERED

B. Other Ambulatory Services

In addition to the aforementioned rural health clinic services, other ambulatory services provided by the clinic may be reimbursed by the KMAP through the Rural Health Clinic Services element.

These services must be provided directly by appropriately licensed clinic staff, in accordance with the State Plan requirements, policies and procedures of the individual Program element.

Included among these services are the following Program elements:

1. Medical
2. Dental
3. Family Planning
4. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
5. Pharmacy
6. Laboratory

A brief description of each of the aforementioned service elements is included in the following pages of this section. Detailed information for each service, including procedure codes for billing purposes, is available upon request to any clinic choosing to provide a particular service and meeting the requirements for its provision.

Please contact:

Cabinet for Human Resources
Department for Medicaid Services
Division of Policy and Provider Services
275 East Main Street
Frankfort, Kentucky 40621
(502) 564-6890

C. Non-Covered Services

1. All institutional services

2. Housekeeping, babysitting, and other homemaker services of like nature

3. Services which are not provided in accordance with restrictions imposed by law or regulation.

4. Services for which the recipient has no obligation to pay and for which no other person has a legal obligation to provide or to make payment.

NOTE: Limitations and Prior Authorization

1. Limitations in covered services are addressed within the description of each specific category of service.

2. Services requiring prior-authorization are explained within the description of each specific category of service.

D. Medical

Diagnostic and treatment services (within the scope of their licensure) as provided by a licensed physician and advanced registered nurse practitioner on the staff of the Rural Health Clinic.

1: Exclusions from Coverage

a. Procedures purely for cosmetic purposes

b. Any service not performed in compliance with State and Federal requirements

c. Autopsy procedures

2. Inpatient Admissions

In order to be considered a "covered inpatient admission" by the KMAP, an admission must be primarily for treatment indicated in the management of an acute or chronic illness, injury or impairment,' or for obstetrical care.

NOTE: If the admission is determined by the KMAP to be a "non-covered" admission, neither the hospital nor the Primary Care Center will be reimbursed by the KMAP for that admission. Those admissions primarily for elective procedures or cosmetic procedures are excluded from coverage by the Program unless medically necessary or indicated.

Hospital admissions for diagnostic procedures can be reimbursed only when there is adequate documentation that the procedures cannot be performed on an outpatient basis. Readmissions are payable only when an acute worsening of an existing condition occurs, or when an entirely new condition develops requiring hospitalization primarily for treatment indicated in the management of acute or chronic illness, injury or impairment or for obstetrical care. Written descriptive verification of the recipient's condition necessitating readmission may be required before such readmission can be considered for payment.

All non-emergency hospital admissions must be pre-authorized by PEERVIEW in order for the KMAP to reimburse the admitting hospital. Prior to the proposed admission, a responsible person in the primary care center's office must contact the PEERVIEW office for pre-admission review. PEERVIEW office staff will assign the initial number of days allowed for the type of admission and provide the pre-admission authorization number. The number of days allowed is considered the standard length of stay for the type of admission barring complications. Both the pre-authorization number and the days approved should be given to the hospital during admission procedures. Emergency

admissions and deliveries do not require a pre-authorization number. Extensions beyond the initial number of days require no action on the part of the primary care center. This is a process between PEERVIEW and the hospital.

The toll-free phone number for PEERVIEW KMAP pre-admission reviews is 1-800-423-6512. This number is answered Monday through Friday 8:00-5:30 central time and 9:00-6:30 eastern time.

3. Sterilizations

The KMAP will make payment for sterilizations only when the following conditions are met:

a. The recipient voluntarily requests the procedure and is advised at least thirty days before the sterilization procedure of the nature of the sterilization procedures to be performed, of the alternative methods of family planning and of the discomforts, risks, and benefits associated with it. Also, the recipient must be advised that his/her consent to be sterilized can be withdrawn at any time and will not effect his/her entitlement to benefits provided by Federal funds.

b. The recipient signs a Sterilization Consent Form (MAP-250) and is advised that a decision not to be sterilized will not affect his or her entitlement to benefits under any government assistance program. The Sterilization Consent Form must be signed by the recipient and the person obtaining the consent at least thirty days before the surgery except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery. No more than one hundred and eighty (180) days may elapse between the date the consent form is signed and the date on which the procedure is performed.

c. The recipient is twenty-one (21) years old or older, at the time of signing the consent form.

d. The recipient must not have been legally declared mentally incompetent unless he or she has been declared competent for purposes which include the ability to consent to sterilization; or must not be institutionalized. The fact that a facility is classified as an SNF, ICF or ICF/MR is not necessarily determinative of whether persons residing therein are "institutionalized." A person residing in an SNF, ICF, or ICF/MR is not considered to be an "institutionalized individual" for the purposes of the regulations unless that person is either: (a) involuntarily confined or detained under a civil or criminal statute in one of those facilities; or (b) confined under some form of a voluntary commitment, and the facility is a mental hospital or a facility for the care and treatment of mental illness.

e. The physician who performs the procedure must sign and date the form MAP-250 after the sterilization procedure is performed.

f. Interpreters must be provided when there are language barriers, and special arrangements must be made for handicapped individuals.

g. To reduce the chances of sterilizations being chosen under duress, a consent may not be obtained from anyone in labor or childbirth, under the influence of alcohol or other drugs, or seeking or obtaining an abortion.

h. These regulations apply to medical procedures performed for the purpose of producing sterility.

i. Reimbursement is not available for hysterectomies performed for sterilization purposes.

j. All applicable spaces of form MAP-250 must be completed and the form must accompany all claims submitted for payment for a sterilization procedure.

In those cases where a sterilization is performed in conjunction with another surgical procedure (e.g., cesarean section, cyst removal) and compliance with Federal regulations governing payment for the sterilization has not been met, EDS can only make payment for the non-sterilization procedures.

See Appendix IX for a copy of the MAP-250 and instructions for completion of the form.

4. Hysterectomies

Title XIX funds can be expended for hysterectomies that are medically necessary only under the following conditions:

a. The person who secures the authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render her permanently incapable of reproduction; and

b. The individual or her representative, if any, has signed and dated the Hysterectomy Consent Form (MAP-251).

c. This Hysterectomy Consent Form (MAP-251) must accompany all claims submitted for payment for hysterectomies, except in the following situations:

(1) The individual was already sterile at the time of the hysterectomy; or

(2) The individual required a hysterectomy because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible.

The physician must certify in writing either the cause of the previous sterility, or that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency. Such documentation must accompany any hysterectomy procedure for which a Hysterectomy Consent form (MAP-251) was not obtained.

d. If the service was performed in a period of retroactive eligibility, the physician must certify in writing that the individual was previously informed that the procedure would render her incapable of reproducing, or that one of the exempt conditions was met.

See Appendix VIII for a copy of the MAP-251 and instructions for completion of the form.

5. Abortion, Miscarriages and Induced Premature Births

KRS 205.560 specifies the conditions under which the KMAP can make payment for induced abortions, induced miscarriages and premature births for Title XIX recipients.

The law states in part that Title XIX Program payment cannot be made "where such aid is for the purpose of obtaining an abortion, induced miscarriage or induced premature birth unless, in the opinion of a physician such a procedure is necessary for the preservation of the life of the woman seeking such treatment or except an induced premature birthended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child."-

The appropriate certification forms (MAP-235 or MAP-236), indicating the procedure used and signed by the physician, must accompany all invoices requesting payment for these services.

See Appendix X-A and X-B for copies of the MAP-235 and MAP-236.

6. Gastric Bypass Surgery

Gastric bypass surgery and other such procedures, including the jejunoileal bypass procedure and gastric stapling, are considered possibly cosmetic procedures and therefore are non-payable unless they meet all of the following criteria:

a. There is documentation that the recipient suffers from other conditions to an extent dangerous to his/her health, e.g. high blood pressure, diabetes, coronary disease, etc.

b. There is documentation that all other forms of weight loss have been exhausted, with legitimate efforts on the part of the physician and recipient, i.e. dieting, exercise, and medication.

c. There is documentation that the sources of weight gain have been identified and subsequently, treatment was attempted in accordance with the diagnosis.

d. There is documentation that prior to the surgery at least one (1) other physician besides the surgeon has been consulted and has approved of the surgical procedure as a last resort of treatment.

e. The recipient is at least 100 pounds over the maximum weight of his/her height and weight category as determined by the attending physician.

It is necessary that the above information accompany each claim submitted for these procedures.

7. Consultations

All consultations billed to the KMAP must include physician/patient contact. Consultations without physician/patient contact are not billable services.

Consultations must have resulted from a specific referral request and have written communication between the consulting and referring physicians as to the results of the examination or evaluation of the recipient. This policy will be monitored through post-payment review.

The name or KMAP provider number of the referring physician must be indicated in Block #8 of the MAP-7 claim form.

8. Procedural Coding

The Health Care Financing Administration (HCFA) Common Procedural Coding System (HCPCS) is utilized by the Program for procedural coding purposes to identify medical services rendered eligible recipients. The HCPCS codes consist of three major sections: national codes, local codes, and CPT-4 codes. The national and local codes, applicable to primary care services, can be found under the appropriate service element in this manual. The CPT-4 codes are listed in the CPT-4 Procedure Coding Manual which can be obtained at the following address:

CPT-4th Edition 1987
Order Dept. OP-341-5
American Medical Association
P.O. Box 10946
Chicago, Illinois 60610

Below are procedures listed in the CPT-4 coding book which are not covered by the KMAP.

NON-COVERED PROCEDURE CODES
In order as listed in CPT 1987 Book

Codes	Description
90749	Unlisted Immunization Procedure
90799	Unlisted Therapeutic Injection
90880-90899	Other Psychiatric Therapy
92070	Special Ophthalmological Services
92314-92326	Contact Lens Services
92330	Ocular Prosthetics, Artificial Eye
92335	Ocular Prosthetics, Artificial Eye
92342	Spectacle Services (Including Prosthesis for Aphakia)
92353	Spectacle Services (Including Prosthesis for Aphakia)
92354	Spectacle Services (Including Prosthesis for Aphakia)
92355	Spectacle Services (Including Prosthesis for Aphakia)
92358	Spectacle Services (Including Prosthesis for Aphakia)
92390-92396	Supply of Materials
95135	Allergen Immunotherapy
95150	Allergen Immunotherapy
95199	Unlisted Allergen Immunotherapy
99000-99015	Administrative Services
99024	Administrative Services
99025	Administrative Services
99052	Administrative Services
99054	Administrative Services
99056	Administrative Services
99058	Administrative Services
99070	Administrative Services
99071	Administrative Services
99075	Administrative Services
99078	Administrative Services
99080	Administrative Services
99090	Administrative Services
99100-99140	'Qualifying Circumstances for Anesthesia
99155	Prolonged Services
99156	Prolonged Services
00100-01999	Anesthesia Procedures
11920-11954	Introduction

NON-COVERED PROCEDURE CODES
In order as listed in CPT 1987 Book
(Continued)

Codes	Description
55970	Intersex Surgery
55980	Intersex Surgery
58310-58311	Artificial Insemination
59050	Internal Fetal Monitoring
59400	Delivery, Antepartum & Postpartum Care (Total Care)
69090	External Ear Incision
78890	Miscellaneous Studies
78891	Miscellaneous Studies
78895	Miscellaneous Studies
78990	Miscellaneous Studies
82441	Chemistry and Toxicology
82635	Chemistry and Toxicology
82720	Chemistry and Toxicology
83088	Chemistry and Toxicology
83645	Chemistry and Toxicology
83670	Chemistry and Toxicology
86209	Immunology
86280	Immunology
86385	Immunology
86386	Immunology
86660	Immunology
87003	Micro Biology
88000-88099	Anatomic Pathology Postmortem Examination
89329-89330	Sperm Evaluation

Some HCPCS procedure codes are "By Report" procedures. These codes require that an operative report be attached behind each claim. A list of the HCPCS "By Report" Procedure Codes can be found in the Appendix of this manual.

Only services actually performed can be billed for. The procedure code which most accurately and completely describes. the service performed is to be selected for billing purposes to the KMAP. The charge made to the KMAP should be the same charge made for comparable services provided to any party or payor.

E. Dental

Dental Services must be provided by a licensed dentist on the staff of the rural health clinic and are limited to the procedures covered through the Dental Services element of the KMAP.

All covered dental services are listed with limitations and applicable procedure codes for billing purposes on the Dental Benefit Schedule. This schedule is available upon request as an addendum to this manual.

F. Family Planning Services

Family Planning Services are to be provided as a package to include the components required under the family planning element of the Program. The services are covered when provided by a physician or licensed advanced registered nurse practitioner (including nurse midwife).

The Benefit Schedule including applicable procedure codes and requirements are available upon request as an addendum to this manual.

G. Early and Periodic Screening Diagnosis and Treatment Services (EPSDT)

Early and Periodic Screening Diagnosis and Treatment Services is a program of preventive health services offered to all recipients from birth through age 20. The Benefit Schedule and requirements are available, upon request, as an addendum to this manual.

H. Pharmacy

Rural Health Clinics, with a licensed pharmacist on staff and an on-site pharmacy holding an operation permit from the Board of Pharmacy in the state in which the clinic is located, may bill for drugs included on the KMAP Outpatient Drug List.

Details of this coverage are available upon request as an addendum to this manual.

I. Laboratory

The following lists laboratory procedures that can be billed by either a licensed physician (M.D.) or Advanced Registered Nurse; Practitioner (ARNP) if the rural health clinic does not have a certified laboratory and technicians on-site and the services are rendered on-site directly by the M.D. or ARNP.

Procedure	Code Number
Throat Cultures (Screening)	87081; 87082; 87083; 87084; 87085
Smears for Bacteria, Stained	87205
Bleeding Time	85000; 85002
Red Blood Count	85041
Hemoglobin	85018
White Blood Count	85048
Differential	85007; 85009
Complete Blood Count	85021; 85022; 85028; 85031
Hematocrit	85014
Platelet Count	85580; 85585; 85590; 85595
Prothrombin Time	85610; 85612; 85614
Sedimentation Rate	85650; 85651
Glucose (Blood)	82947; 82949; 84948
Blood Urea Nitrogen	84520; 84525; 84540
Uric Acid	84550
Urine Analysis (Chemical and Microscopic)	81000; 82615
Thyroid Profile	84435; 84443; 84437; 84800; 82756; 84479
Glucose Tolerance	82951, W8724, 82952
Electrolytes	80003; 80002
Ova and Parasites	87177
TB Tests	86585; 86580
Coccidioidomycosis	86490
Histoplasmosis	86510
Mumps	86540
Brucella	86002

A Complete Blood Count (CBC) must be used when billing 3 or more of the following tests: 85007 or 85009, 85041, 85018, 85048, or 85014. When three or more components are performed, the CBC must be billed, and no additional component is allowed. 8

Laboratory tests can not be billed to the KMAP for services rendered to residents of skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded and developmentally disabled, when the resident is in vendor payment status with the KMAP.

J. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which, as an adjunct to the Kentucky Medical Assistance Program (KMAP), provides certain categories of medical recipients with a primary physician or family doctor. Only those Medicaid recipients who receive medical assistance under the Aid to Families with Dependent Children (AFDC), or AFDC-related categories are covered by KenPAC. Specifically excluded are: the aged, blind, and disabled categories of recipients; skilled nursing facility (SNF), intermediate care facility (ICF), and personal care (PC) residents; mental hospital patients; foster care cases; refugee cases; all spend-down cases; and all Lock-In cases. To aid in distinguishing from regular KMAP recipients, the KenPAC recipients will have a color-coded KMAP card with the name, address, and telephone number of their primary care provider.

Primary physician specialists or groups who may participate as primary physicians are:

General Practitioners	Obstetricians	Primary Physician Clinics
Family Practitioners	Gynecologists	Primary Care Centers
Pediatricians	Internists	Rural Health Clinics

Recipients may select a primary physician/clinic who agrees to participate in Medicaid and KenPAC. Recipients not selecting a primary physician will be assigned one within their home county. A primary physician may serve up to 1,500 KenPAC patients. Provider

clinics may serve up to 1,500 patients for each full-time equivalent physician. Primary Care Centers and Rural Health Clinics may also be assigned recipients based on the number of Advanced Registered Nurse Practitioners (ARNP) they have on staff..

KenPAC primary physicians/clinics must arrange for physician coverage 24 hours per day, seven days per week. A single 24 hour access telephone number must be provided by the primary physician/clinic. This number will be printed on the recipient's KenPAC Medical Assistance Identification Card.

The following service categories must be provided either by the primary physician/clinic or referred by the primary physician/clinic in order to be reimbursed by KMAP.

Physician (excludes Ophthalmologists and Psychiatrists)
Hospital (Inpatient)(Excludes Psychiatric and Obstetrical Admissions)
Hospital (Outpatient)
Laboratory Services
Nurse Anesthetists
Rural Health Clinic, Services
Home Health Services
Primary Care Centers
Ambulatory Surgical Centers

Services not included in the above list may be obtained by the KenPAC recipient in the usual manner. These services are as follows:

Dental	Early Periodic Screening	Obstetrical and Routine
Pharmacy	Diagnosis & Treatment	Newborn Care
Family Planning	Hearing and Vision	

Referrals may be made by the KenPAC primary physician/clinic to another provider for specialty care or for primary care during his/her absence. No special authorization or referral form is required, and referrals should occur in accordance with accepted practices in the medical community. However, to ensure that payment will be made, the primary physician/clinic must provide the specialist or other physician with his/her KMAP vendor number, which is to be entered on the billing form to signify that the service has been authorized. Claims for services provided to KenPAC recipients which do not have a referral from their primary physician will not be paid by KMAP.

"Emergency Care" is defined as a condition for which a delay in treatment may result in death or permanent impairment of health.

Pre-authorization from the primary physician is not required for emergency care. However, the primary physician should be contacted, whenever practical, to be advised that care has been provided, and to obtain the physician's authorization number. If the authorization cannot be obtained from the primary physician, the provider must contact the Medicaid Program to obtain an authorization number before submitting a claim.

"Urgent care" is defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for a normally scheduled appointment (e.g., suturing minor cuts, setting simple broken bones, treating dislocated bones, and treating conditions characterized by abnormally high temperatures).

The primary physician must be contacted for prior authorization of urgent care. If prior authorization is refused, any service provided to the client is not payable by the Kentucky Medical Assistance Program. If the recipient's primary physician cannot be reached for prior authorization, urgent care is to be provided and the necessary authorization secured after service is rendered. Under this circumstance, if post-authorization is refused by the primary physician or the primary physician cannot be contacted after service has been provided, special authorization can be obtained from the Medicaid Program. When the Program determines that the special authorization procedure is being misused, the individual provider will be advised that special authorization for further services may be refused.

Routine care in the emergency room is not to be authorized by the primary physician, and will not be payable under the Program.

KenPAC primary physicians and clinics, in addition to their normal fee for service reimbursements from Medicaid, will be paid $3.00 per month for each KenPAC patient they manage. Maximum monthly reimbursement may not exceed $3,000.00 per physician.

Any questions about the KenPAC Program may be referred to:

Manager, KenPAC Branch
Division of Policy and Provider Services
Department for Medicaid Services
275 East Main Street
Frankfort, KY 40621

Information may be obtained by calling toll free I-800-635-2570 (In-State) or l-502-564-5198 (In- or Out-of-State).

K. Lock-In Recipients

The Lock-In Program was implemented for recipients who have been identified as using physician and/or pharmacy services inappropriately. Utilization review of recipient participation patterns demonstrates exceptional or excessive use of these Program benefits. Recipients in this category are placed in the Lock-In Program to assist them in establishing: (a) a physician-patient relationship, (b) continuity of care, and (c) to safeguard against the dispensing of contraindicated drugs by multiple physicians and pharmacies.

In order to accomplish these goals, all Lock-In recipients are subject to the following limitations in covered services:

a. Recipients who are selected for Lock-In receive special pink Medical Assistance Identification cards each month. Each member of the selected-family unit is issued this card and placed on special status. Physician and/or pharmacy services must be provided by the Lock-In provider only.

b. Physician and/or pharmacy services rendered by persons other than the Lock-In provider are considered non-covered services except as follows:

(1) The recipient requires physician services at an emergency room, in-patient or out-patient hospital, community mental health; 'family planning, etc.

(2) The recipient requires treatment due to an acute illness, arising after hours, weekends, holidays. Claims will be considered if documentation is provided that indicates the medical necessity of the service (i.e., Lock-In provider not available, injury/accident, recipient out of town).

(3) The recipient's Lock-In provider determines that the services of a consultant or specialist are medically necessary. This includes second opinions for surgery etc. Claims will be considered for payment if the name and number of the Lock-In provider are entered in Block #8 of the MAP-7 claim form.

c. The recipient will remain on the Lock-In Program until payment profiles indicate that the recipient's utilization pattern is within acceptable parameters. The recipient is not permitted to change Lock-In providers unless:

(1) The recipient or provider moves;

(2) The provider requests a change; or

(3) Sufficient evidence is provided to indicate that a change is in the best interest of the recipient.

Physicians are encouraged to notify the Department for Medicaid Services regarding specific cases of apparent inappropriate utilization of Program benefits. Recipient utilization profiles are then developed for consideration of recipient inclusion in the Lock-In Program.

SECTION V - REIMBURSEMENT

V. REIMBURSEMENT

Definitions:

1. A "provider based rural health clinic" is one which is an integral part of a hospital, skilled nursing facility, or home health agency that is participating in Medicare and is licensed, governed, and supervised with other departments of the facility.

2. An "independent rural health clinic" is one which is participating in Medicare and which is not provider based.

3. "Visit" means a face-to-face encounter between a clinic patient and any clinic health professional whose services are' reimbursed under the rural health clinic payment method. Encounters with more than one (1) health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

A. Methods of Reimbursement.

1. Provider Based Clinics.

Licensed participating provider based rural health clinics will be reimbursed on the following basis:

a. The reasonable cost for provider based rural health clinic services and other ambulatory services provided to eligible medical assistance recipients on the basis of Medicare methodology.

b. Payments shall be made at interim rates which approximate costs on a per visit basis. For Medicare covered services, which are also covered by Medicaid, the interim rate shall be the rate set by the Medicare intermediary. For Medicaid only services, the interim rate shall be set by the department taking into account prior year data when possible. For new facilities, the department shall set the interim rate using a methodology which is expected to approximate costs and review the interim rate approximately six (6) months after such rate has been set to ensure the reasonableness of the rate.

2. Independent Clinics

Licensed participating independent rural health clinics will be reimbursed on the following basis:

a. A single rate per visit that is based on the cost of all services furnished by the clinic. The rate shall be determined by the Medicare carrier, Blue Cross/Blue Shield of Tennessee, in accordance with the Medicare methodology.

b. The Medicaid all inclusive rate per visit will include the cost to provide "rural health clinic services" (those covered by Medicare) as well as "other ambulatory services" those covered only by Medicaid.

NOTE: A billable service, one that will generate a payment of the established rate per visit, is defined as a visit or encounter which includes a face-to-face contact and a professional medical service by either a physician, nurse practitioner, dentist, or optometrist on the staff of the Rural Health Clinic.

A billable service is limited to a single professional visit on a given day regardless of the number or variety of services received during such visit (i.e.,, only one Medicaid bill per day can be generated). However, this does not preclude two or more billable services (i.e., Medicaid bills) from being generated if 1) the patient is seen at different locations on the same day or 2) has a second visit at the same location which resulted from a different circumstance, purpose, or need.

B. Medicare, Title XVIII Coverage

The KMAP assumes responsibility for a recipient's Medicare (Title XVIII) deductible and coinsurance liability for covered services.

The rural health clinic shall bill the Medicare Intermediary prior to billing EDS. If billing Medicare on the HCFA-1500 billing form, the rural health center must neither check the "Medicaid" block on the HCFA-1500 form nor enter the Medical Assistance Identification Number and must choose one of the following:

1) Require recipient to sign the HCFA-1500 claim form for Medicare purposes; or

2) Obtain a blanket assignment from the recipient which will permit the provider to enter the words "BLANKET ASSIGNMENT ON FILE" in the signature block of the HCFA-1500.

The MAP-7 form shall then be completed as for any recipient, except that the amount received from Medicare is to be reported in Block #29 and a copy of the Medicare Explanation of Benefits (EOMB) is to be attached to the claim. Payment for the services reflected on the invoice will be the center's interim rate (CAC) less the amount from Medicare.

C. Reimbursement in Relation to Other Third Party Coverage (excluding Medicare)

1. General

To expedite the Medicaid claims processing payment function, the provider of Medicaid services must actively participate in the identification of third party resources for payment on behalf of the recipient. At the time the provider obtains Medicaid billing information from the recipient, he/she should determine if additional resources exist. Providers have an obligation to investigate and to report the existence of other insurance or liability. The provider's cooperation will enable the Kentucky Medicaid program to function efficiently.

2. Identification of Third Party Resources

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider should inquire if the recipient meets any of the following conditions: If the recipient is married or working, inquire about possible health insurance through the recipient's or spouse's employer; if the recipient is a minor, ask about insurance the mother, father, or guardian may carry on the recipient; in cases of active or retired military personnel, request 'information about CHAMPUS coverage and social-security number of the policy holder; for people over 65 or disabled, seek a Medicare HI number; ask if the recipient has health insurance such as a Medicare Supplement policy, cancer, accident, or indemnity policy, group health or individual insurance, etc., EXAMINE THE RECIPIENT S MONTHLY ELIGIBILITY CARD FOR AN INSURANCE INDICATOR AND IF AN INDICATOR IS PRESENT, QUESTION THE RECIPIENT FURTHER REGARDING OTHER INSURANCE.

3. Private Insurance

If the patient has third party resources, then the provider must obtain payment *or* rejection from the third party before Medicaid can be filed. When payment is received, the provider should indicate on the claim form in the appropriate field the amount

of the third party payment and the name and policy number of health insurance covering the recipient. If the third party rejected the claim, a copy of the rejection notice must be attached to the Medicaid claim.

Exceptions:

*If the other insurance company has not responded within 120 days of the date of filing a claim to the insurance company, submit with the Medicaid claim a copy of the other insurance claim to EDS indicating "NO RESPONSE" on the Medicaid claim form. Then forward a completed TPL Lead form to:

EDS
P.O. Box 2009
Frankfort, KY 40602
Attn: TPL Unit

*If proof of denial for the same recipient for the same or related services from the carrier is attached to the Medicaid billing, claims processing can proceed. The denial cannot be more than six months old.

*A letter from the provider indicating that he/she contacted XYZ insurance company and spoke with an agent to verify that the recipient was not covered, can also be attached to the Medicaid claim.

4. Medicaid Payment for Claims Involving a Third Party

Claims meeting the requirements for KMAP payment will be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party will be deducted from the Medicaid allowed amount and the difference paid to the provider. If the third party payment amount exceeds the Medicaid allowed amount, the resulting KMAP payment will be zero. Recipients cannot be billed for any difference between the billed amount and Medicaid payment amount. Providers must accept Medicaid payment as payment in full.

If the claims for a recipient are payable by a third party resource which was not pursued by the provider, the claim will be denied. Along with a Third Party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number will be indicated. The provider must pursue payment with this third party resource before billing Medicaid again.

5. Accident and Work Related Claims

For claims billed to Medicaid that are related to an accident or work related incident, the provider should pursue information relating to the accident. If an attorney, employer, individual or an insurance company is liable for payment, payment must be pursued from the liable party. If the liable party has not been determined, attach copies of any information obtained, such as, the names of attorneys, other involved parties and/or the recipient's employer to the claim when submitting to EDS for Medicaid payment.

D. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by the KMAP, whether due to erroneous billing or payment system faults, must be refunded to the KMAP. Refund checks should be made payable to "Kentucky State Treasurer" and sent immediately to:

EDS
P.O. Box 2009
Frankfort, KY 40602

ATTN: Cash/Finance Unit

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse, and prosecuted as such.

VI. COMPLETION OF INVOICE FORM

A. General

The Health Insurance Claim Form HCFA-1500 (12/90) shall be used to bill for all rural health services rendered eligible Kentucky Medicaid Program recipients.

The original of the two part invoice set shall be submitted to EDS as soon as possible after the service is provided. The carbon copy of the invoice shall be retained by the provider as a record of claim submitted.

Invoices shall be mailed to:

EDS
P.O. Box 2018
Frankfort, Kentucky 40602

B. Completion of the Health Insurance Claim Form (12/90)

An example of a Health Insurance Claim Form HCFA-1500 (12/90) is shown in the appendix. Instructions for the proper completion of this form are presented below.

IMPORTANT: The patient's Kentucky Medical Assistance Identification Card shall be carefully checked to see that the patient's name appears on the card and that the card is valid for the period of time in which the medical services are to be rendered. There can be no payment for services rendered to an ineligible person.

The age of the patient shall also be reflected on the Identification Card. This shall be noted, specifically in cases where the patient requires services that are limited to recipients under or over the age of 21.

SECTION VI - COMPLETION OF INVOICE FORM

HCFA-1500 (12/90) forms may be obtained from:

U.S. Goverment
Superintendent of Documents
Washington, D.C. 20402

Telephone: 1-800-621-8335

BLOCK NO.	BLOCK NAME AND DESCRIPTION

2 PATIENT'S NAME

Enter the recipient's last name, first name, middle-initial exactly as it appears on the current Medical Assistance Identification (MAID) card.

9A OTHER INSURED'S POLICY OR GROUP NUMBER

Enter the recipient's ten digit Medical Assistance Identification (MAID) number exactly as it appears on the current MAID card.

10B,C ACCIDENT

Check the appropriate block if treatment rendered was necessitated by some form of accident.

11 INSURED'S POLICY GROUP OR FECA NUMBER

Complete if the recipient has any kind of private health insurance that has made a payment, other than Medicare.

11C INSURANCE PLAN NAME OR PROGRAM NAME

Enter the name of the insurance company or program name.

19 RESERVED FOR LOCAL USE

Required for Kenpac and Lock-In recipients who are referred for treatment. Enter the eight-digit Medicaid provider number of the referring KenPac or Lock-In provider.

SECTION VI - COMPLETION OF INVOICE FORM

BLOCK NO.	BLOCK NAME AND DESCRIPTION
24G	DAYS OR UNITS Enter the number of times this procedure was provided for the recipient on this date of service. For pharmacy services, enter the quantity of each prescription billed.
24H	EPSDT FAMILY PLAN Enter a "Y" if the treatment rendered was a direct result of an Early and Periodic Screening, Diagnosis and Treatment Program.
24K	RESERVED FOR LOCAL USE When billing pharmacy services, enter the prescription number. When billing dental services, enter the tooth number(s). Enter the vaccine dose for vaccinations. Enter the EPSDT referral codes, if applicable, for EPSDT services.
26	PATIENT'S ACCOUNT NO. Enter the patient account number, if desired. EDS will key the first seven or fewer digits. This number will appear on the Remittance Statement as the invoice number.
28	TOTAL CHARGES Enter the total of the individual procedure charges listed in column 24F.
29	AMOUNT PAID Enter the amount.received by private insurance. DO NOT INCLUDE Medicare. If no private insurance payment, leave blank.
30	BALANCE DUE Enter the amount received from Medicare, otherwise leave blank.

SECTION VI - COMPLETION OF INVOICE FORM

BLOCK NO.	BLOCK NAME AND DESCRIPTION
31	SIGNATURE/ INVOICE DATE The actual signature of the provider (not a facsimile) or the provider's appointed representative is required. Stamped signatures are not acceptable.
33	PROVIDER NUMBER Enter the name and address of the provider submitting the claim. Beside PIN # enter the eight-digit individual Medicaid provider number.

Claims for covered services shall be received by EDS withing twelve (12) months from the date of service. Claims with service dates more than twelve (12) months old can be considered for processing only with appropriate documentation such as: Remittance Statements which verify timely filing, backdated MA, ID cards, Social Security documents, Return to Provider letters, etc.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

NEW FORM

APPENDIX VII

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

(Medicare #) | (Medicaid #) | (Sponsor's SSN) | (VA File #) | (SSN or ID) | (SSN) | (ID)

1. PATIENT'S NAME (Last Name. First Name. Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

5. PATIENT'S ADDRESS (No.. Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

CITY STATE

8. PATIENT STATUS Single | Married | Other

Employed | Full-Time Student | Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name. First Name. Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

b. AUTO ACCIDENT? PLACE (State) YES NO

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX ID NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB.1500
FORM OP 050191

TRANSMITTAL #13

SECTION VI - COMPLETION OF INVOICE FORM

24 DIAGNOSIS TREATED

Enter the applicable number from note 2 (diagnosis treated). Required for all medical services (excludes only dental and drug services).

25 PROCEDURE CHARGES

Enter the usual and customary charge, for the service rendered.

26 No entry required.

27 TOTAL CLAIM CHARGE

Enter the total of lines 1 - 10.

28 HEALTH INSURANCE AMOUNT

Enter the total amount (if any) received from the patient's health insurance for services billed.

29 AMOUNT FROM MEDICARE

Enter the total amount received from Medicare for services billed. Attach a copy of the Medicare Explanation of Benefits to claim.

30 PROVIDER NAME

Enter the name and address of the Rural Health Clinic performing the services being billed.

31 PROVIDER NUMBER

Enter the eight-digit Medicaid provider number assigned to the provider listed in block 30.

32 AUTHORIZED SIGNATURE

The actual signature of the provider or authorized representative is entered here.

SECTION VI - COMPLETION OF INVOICE FORM

33 COUNTY

No entry required.

34 AREA

No entry required.

35 INVOICE DATE

Enter the month, day, and year that the invoice was signed and submitted to EDS (i.e., November 15, 1987 would be entered 11 15 87).

36 DATE OF SERVICE

Enter the month, day and year (numeric equivalent as block 35) the services were provided. One date of service per claim.

37 CHARGE DISPOSITION

No entry required.

38 INVOICE NUMBER

No entry required.

39 No entry required.

****
Claims for covered services must be received by EDS within twelve
*(12) months from the date of service. Claims with service dates *
more than twelve (12) months old can be considered for processing
*only with appropriate documentation such as one or more of the *
*following: Remittance Statements no more than 12 months of age *
*which verify timely filing, backdated MAID cards with "Backdated *
*Card" written on the attached claim, Social Security documents, *
*correspondence describing extenuating circumstances, Action *
*Sheets, Return to Provider Letters, Medicare Explanation of *
*Medical Benefits, etc. *
****

SECTION VII - REMITTANCE STATEMENT

VII. REMITTANCE STATEMENT

A. General

The EDS Remittance Statement (Remittance Advice) furnishes the provider with an explanation of the status of those claims EDS processed. The Remittance Statement accompanies the payment check and is divided into six sections.

The first section provides an accounting of those claims which are being paid by the KMAP with the accompanying payment check.

The second section provides a list of claims which have been rejected (denied) in total by the KMAP with the corresponding Explanation of Benefit (EOB) code.

The third section provides a list of claims EDS received which did not complete processing as of the date indicated on the Remittance Statement.

The fourth section provides a list of claims received by EDS that could not be processed as the result of incomplete claim information. These claims have been returned to the provider along with a cover letter that explains the reasons for the return.

The fifth section includes the summation of claims payment activity as of the date indicated on the Remittance Statement and the year-to-date claims payment activities.

The sixth section provides a list of the EOB codes which appeared on the dated Remittance Statement with the corresponding written explanation of each EOB code.

Claims appearing in any section of the Remittance Statement will be in alphabetical order according to the patient's last name.

B. Section I - Claims Paid

An example of the first section of the Remittance Statement is shown in Appendix XII-A. This section lists all of those claims for which payment is being made. On the pages immediately following are item-by-item explanations of each individual entry appearing on this section of the Remittance Statement.

EXPLANATION OF REMITTANCE STATEMENT
FOR RURAL HEALTH SERVICES

ITEM	
INVOICE NUMBER	The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column for the provider's reference
RECIPIENT NAME	The name of the recipient as it appears on the Department's file of eligible Medicaid recipients
RECIPIENT NUMBER	The Medical Assistance I.D. Number of the' recipient as shown on the claim form submitted by the provider
INTERNAL CONTROL NO.	The internal control number (ICN) assigned to the claim for identification purposes by EDS
CLAIM SVC DATE	The earliest and latest dates of service as shown on the claim form
TOTAL CHARGES	The total charges billed by the provider for the services on this claim form
AMT. FROM OTHER SRCS	The amount indicated by the provider as received from a source other than the Medicaid program for services on this claim
CLAIM PMT AMOUNT	The amount being paid by the Medicaid Program to the provider for this claim

EOB	For explanation of benefit code, see back page of Remittance Statement
LINE NO	The number of the line on the claim being printed
POS	Place of service code depicting the location of the rendered service
PROC	Procedure code in the line item
DRUG CODE	The drug code of the prescription that was dispensed
RX	The prescription number used by the pharmacist to identify this prescription
QTY	The quantity of the prescription that was dispensed
EOB	Explanation of benefit code which identifies the payment process used to pay the line item

C. Section II - Denied Claims

The second section of the Remittance Statement appears whenever one or more claims are rejected in total. This section lists all such claims and indicates the EOB code explaining the reason for each claim rejection. Appendix XII-B.

All items printed have been previously defined in the descriptions of the paid claims section of the Remittance Statement.

D. Section III - Claims in Process

The third section of the Remittance Statement (Appendix XII-C) lists those claims which have been received by EDS but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of data errors or the need for further review. A claim only appears in the Claims In Process section of the Remittance Statement as long as it remains in process. At the time a final determination can be made as to claim disposition (payment or rejection) the claim will appear in Section I or II of the Remittance Statement.

E. Section IV - Returned Claims

The fourth section of the Remittance Statements (Appendix XII-D) lists those claims which have been received by EDS and returned to the provider because required information is missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

F. Section V - Claims Payment Summary

This section is a summary of the claims payment activities as of the date indicated on the Remittance Statement and the year-to-date (YTD) claims payment activities.

CLAIMS PAID/DENIED, the total number of finalized claims which have been determined to be denied or paid by the Medicaid program, as of the date indicated on the Remittance Statement and YTD summation of claim activity

AMOUNT PAID the total amount of claims that paid as of the date on the Remittance Statement and the YTD summation of payment activity

WITHHELD AMOUNT	the dollar amount that has been recouped by Medicaid as of the date on the Remittance Statement (and YTD summation of recouped monies)
NET PAY AMOUNT	the dollar amount that appears on the check
CREDIT AMOUNT	the dollar amount of a refund that a provider has sent in to EDS to adjust the 1099 amount (this amount does not affect claims payment, it only adjusts the 1099 amount)
NET 1099 AMOUNT	the total amount of money that the provider has received from the Medicaid program as of the date on the Remittance Statement and the YTD total monies received taking into consideration recoupments and refunds

G. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appeared on the dated Remittance Statement will have a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (Appendix XII-E).

SECTION VIII - GENERAL INFORMATION - EDS

A. Correspondence Forms Instructions

Type of Information Requested	Time Frame for Inquiry	Mailing Address
Inquiry	6 weeks after billing	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Communications Unit
Adjustment	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Adjustments Unit
Refund	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Cash/Finance Unit

Type of Information Requested	Necessary Information
Inquiry	1. Completed Inquiry Form 2. Remittance Advice or Medicare EOMB, when applicable 3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on an R/A within a reasonable, amount of time

Type of Information Requested	Necessary Information
Adjustment	1. Completed Adjustment Form 2. Photocopy of the claim in question 3. Photocopy of the applicable portion of the R/A in question
. Refund	1. Refund Check 2. Photocopy of the applicable portion of the R/A in question 3. Reason for refund

B. Telephoned Inquiry Information

What is Needed?

- Provider number
- Patient's Medicaid ID number
- Date of service
- Billed amount
- Your name and telephone number

When to Call?

- When claim is not showing on paid, pending or denied sections of the R/A within 6 weeks
- When the status of claims are needed and they do not exceed five in number

Where to Call?

- Toll-free number 1-800-372-2921 (within Kentucky)
- Local (502) 227-2525

C. Filing Limitations

New Claims	12 months from date of service
Medicare/Medicaid Crossover Claims	12 months from date of service

NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing.

Third-Party Liability Claims	12 months from date of service

NOTE: If the other insurance company has not responded within 120 days of the date a claim is submitted to the insurance company, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.

Adjustments	12 months from date the paid claim appeared on the R/A

D. Provider Inquiry Form

The Provider Inquiry form should be used for inquiries to EDS regarding paid or denied claims, billing concerns, and claim status. (If requesting more than one claim status, a Provider Inquiry form should be completed for each status request.) The Provider Inquiry form should be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at 1-(800)-372-2921 or l-(502)-227-2525.

Please remit both copies of the Provider Inquiry form to EDS. Any additional documentation that would help clarify your inquiry should be attached. EDS will enter their response on the form and the yellow copy will be returned to the provider.

It is not necessary to complete a Provider Inquiry form when resubmitting a deniedclaim.

Provider Inquiry forms may not be used in lieu of KMAP claim forms, Adjustment forms, or any other document required by KMAP.

In certain cases it may be necessary to return the Inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry form are found on the next page.

Following are field by field instructions for completing the Provider Inquiry form:

Field Number	Instructions
1	Enter your 8-digit Kentucky Medicaid Provider Number. If you are a KMAP certified clinic, enter your 8-digit clinic number.
2	Enter your Provider Name and Address.
3	Enter the Medicaid Recipient's Name as it appears on the Medical Assistance I.D. Card.
4	Enter the recipient's 10 digit Medical Assistance ID number.
5	Enter the Billed Amount of the claim on which you are inquiring.
6	Enter the Claim Service Date(s).
7	If you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Advice listing the claim.
8	If you are inquiring in regard to an in-process, paid, or denied claim, enter the 13-digit internal control number listed on the Remittance Advice for that particular claim.
9	Enter your specific inquiry.
10	Enter your signature and the date of the inquiry.

E. Adjustment Request Form

The Adjustment Request form is to be used when requesting a change on a previously paid claim. This does not include denied claims or claims returned to the provider for requested additional information or documentation.

For prompt action and response to the adjustment requests, please complete all items. COPIES OF THE CLAIM AND THE APPROPRIATE PAGE OF THE R/A MUST BE ATTACHED TO THE ADJUSTMENT REQUEST FORM. If items are not completed, the form may be returned.

Field Number	Description
1	Enter the 13-digit claim number for the particular claim in question.
2	Enter the recipient's name as it appears on the R/A (last name first).
3	Enter the complete recipient identification number as- it appears on the R/A. The complete Medicaid number contains 10 digits.
4	Enter the provider's name, address and complete provider number.
5	Enter the "From Date of Service" for the claim in question.
6	Enter the "To Date of Service" for the claim in question.
7	Enter the total charges submitted on the original claim.

Field Number	Description
8	Enter the total Medicaid payment for the claim as found under the "Claims Payment Amount" column on the R/A.
9	Enter the R/A date which is found on the top left corner of the remittance. Please do not enter the date the payment was received or posted.
10	Specifically state WHAT is to be adjusted on the claim (i.e. date of service, units of service).
11	Specifically state the reasons for the request adjustment (i.e. miscoded, overpaid, underpaid).
12	Enter the name of the person who completed the Adjustment Request Form.
13	Enter the date on which the form was submitted.

Mail the completed Adjustment Request form, claim copy and Remittance Advice to the address on the top of the form.

To reorder these forms, contact the Provider Relations Unit:

EDS
P.O. Box 2009
Frankfort, KY 40602

Be sure to specify the number of forms you desire. Allow 7 days for delivery.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Ambulatory Surgical Center Services

Medicaid covers medically necessary services performed in ambulatory surgical centers.

Birthing Center Services

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up postnatal visits within 4-6 weeks of the delivery date.

Dental Services

Coverage is limited but includes X-rays, fillings, simple extractions, and emergency treatment for pain, infection and hemorrhage. Preventive dental care is stressed for individuals under age 21.

Family Planning Services

Comprehensive family planning services are available to all eligible Title XIX recipients of childbearing age and those minors who can be considered sexually active. These services are offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services are also available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, are available through the Family Planning Services element of the KMAP. Follow-up visits and emergency treatments are also provided.

Hearing Services

Hearing evaluations and single hearing aids, when indicated, are paid for by the program for eligible recipients, to the age of 21. Follow-up visits, as well as check-up visits, are covered through the hearing services element. Certain hearing aid repairs are also paid through the program.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)_SERVICES

Home Health Services

Skilled nursing services, physical therapy, speech therapy, occupational therapy and aide services are covered when necessary to help the patient remain at home. Medical social worker services are covered when provided as part of these services. Home Health coverage also includes disposable medical supplies; and durable medical equipment, appliances and certain prosthetic devices on a preauthorized basis. Coverage for home health services is not limited by age.

Hospital Services

Inpatient Services

KMAP benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions must be preauthorized by a Peer Review Organization. Certain surgical procedures are not covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures are outside the scope of program benefits unless medically necessary or indicated. Reimbursement is limited to a maximum of fourteen (14) days per admission.

Outpatient Services

Benefits of this program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician; clinic visits, selected biological and blood constituents, emergency room services in emergency situations as determined by a physician; and services of hospital-based emergency room physicians.

There are no limitations on the number of hospital outpatient visits or services available to program recipients.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Laboratory Services

The following laboratory tests are covered when ordered by a physician and done in a laboratory certified by the Department of Health and Human Services:

Cultures (Screening)
Blood Culture (definitive)
Stool (Ova and parasites).
Smears for Bacteria, Stained
Bilirubin
Bleeding Time
Red Blood Count
Hemoglobin
White Blood Count
Differential
Complete Blood Count
Cholesterol
Clotting Time
Hematocrit
RA Test (Latex Agglutinations)
Acid Phosphatase
Alkaline Phosphatase
Potassium
Prothrombin Time
Sedimentation Rate
Uric Acid
Stool (Occult Blood)
Pap Smear
Urine Analysis
Urine Culture
Sensitivity Testing
Pregnancy Test
CPK/Creatine
Thyroid Profile
T3
T4
Glucose Tolerance
Electrolytes
Dilantin/Phenobarbital/Drug Abuse Screen
Arthritis Profile
VDRL
Glucose (Blood)
SGOT or SGPT (Serum Transaminase)
Blood Typing
Blood Urea Nitrogen
Sodium
Any 3 or More Automated Tests
Rubella
Therapeutic Drug Monitoring
Lithium
Theophylline
Digoxin
Digitoxn

Long-Term Care Facility Services

Skilled Nursing Facility Services

The KMAP can make payment to skilled nursing facilities for:

A. Services provided to Medicaid recipients who require twenty-four (24) skilled nursing care and/or skilled services which as a practical matter can only be provided on an inpatient basis.*

B. Services provided to recipients who are also medically eligible for Medicare benefits in the skilled nursing facility.

-Coinsurance from the 21st through the 100th day of this Medicare benefit period.
-Full cost for the full length of stay after the 100th day if 24-hour skilled nursing care is still required.*

*Need for skilled nursing care must be certified by a Peer Review Organization (PRO).

Intermediate Care Facility Services

The KMAP can make payment to intermediate care facilities for:

A. Services provided to recipients who require intermittent skilled nursing care and continuous personal care supervision.*

B. Services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age 22, who because of their mental and physical condition require care and services which are not provided by community resources.**

*Need for the intermediate level of care must be certified by a PRO.

**Need for the ICF/MR/DD level of care must be certified by a PRO.

Mental Hospital Services

Inpatient psychiatric services are provided to Medicaid recipients under the age of 21 and age 65 or older in a psychiatric hospital. There is no limit on length of stay; however, the need for inpatient psychiatric hospital services must be verified through the utilization control mechanism.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Community Mental Health Center Services

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

Outpatient Services
Partial Hospitalization
Emergency Services
Inpatient Services
Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health center and possibly avoid hospitalization. There are fourteen (14) major centers, with many satellite centers available. Kentucky Medical Assistance Program reimburses private practicing psychiatrists for psychiatric services through the physician program.

Nurse Anesthetist Services

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist are covered by the KMAP.

Nurse Midwife Services

Medicaid coverage is available for services performed by a participating Advanced Registered Nurse Practitioner - Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up post partum visits within 4 to 6 weeks of the delivery date.

Pharmacy Services

Legend and non-legend drugs from the approved Medical Assistance Drug List when required in the treatment of chronic and acute illnesses are covered by the KMAP. The Deoartment is advised reaardina the outoatient drua coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual.pharmacists and physicians upon request and routinely sent to participating pharmacies and long-term care facilities. The Drug List is distributed quarterly with monthly updates.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL- ASSISTANCE PROGRAM (KMAP) SERVICES

Pharmacy Services (Continued)

In addition, certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization are covered for payment through the Drug Preauthorization Program.

Physician Services

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms must be completed prior to coverage of these procedures.

Non-covered services include:

Injections, immunizations, supplies, drugs (except anti-neoplastic drugs), cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

One comprehensive office visit per twelve (12) month period, per patient, per physician.

Inpatient hospital visits limited to a maximum of fourteen (14) days, per patient, per admission.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Physician/Services (Continued)

The following' laboratory procedures are covered when performed in the office by an M.D. or osteopath.

Ova and Parasites (feces)
Smear for Bacteria, stained
Throat Cultures (Screening)
Red Blood Count
Hemoglobin
White Blood Count
Differential Count
Bleeding Time
Electrolytes
Glucose Tolerance
Skin Tests for:
  Histoplasmosis
  Tuberculosis
  Coccidioidomycosis
  Mumps
  Brucella
Complete Blood Count
Hematocrit
Prothrombin Time
Sedimentation Rate
Glucose (Blood)
Blood Urea Nitrogen (BUN)
Uric Acid
Thyroid Profile
Platelet count
Urine Analysis

Bone Marrow spear and/or cell block; aspiration only
Smear; interpretation only
Aspiration; staining and interpretation
Aspiration and staining only
Bone Marrow needle biopsy
Staining and interpretation
Interpretation only
Fine needle aspiration with or without preparation of smear; superficial tissue
Deep tissue with radiological guidance
Evaluation of fine needle aspirate with or without preparation of smears
Duodenal intubation and aspiration: single specimen
Multiple specimens
Castric intubation and aspiration: diagnostic
Nasal smears for eospinophils
Sputum, obtaining specimen, aerosol induced technique

Podiatry Services

Selected services provided by licensed podiatrists are covered by the Kentucky Medical Assistance Program. Routine foot care is covered only for certain medical conditions where such care requires professional supervision.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Primary Care Services

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits are generally applicable when the services are provided by a primary care center.

Renal Dialysis Center Services

Renal service benefits include renal dialysis, certain supplies and home equipment.

Rural Health Clinic Services

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasizes preventive and maintenance health care for people of all ages. The clinics, though physician directed, must also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

Screening Services

Through the screening service element, eligible recipients, age 0-thru birth month of 21st birthday, may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

- Medical History
- Physical Assessment
- Growth and Developmental Assessment
- Screening for Urinary Problems
- Screening for Hearing and Vision Problems
- Tuberculin Skin Test
- Dental Screening
- Screening for Veneral Disease, As Indicated
- Assessment and/or Updating of Immunizations

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

Transportation Services

Medicaid may cover transportation to and from Title XIX-covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered is preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services. Travel to pharmacies is not covered.

Vision Services

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists are covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs are covered for persons under age 21.

SPECIAL PROGRAMS

KenPAC: The Kentucky Patient Access and Care System, or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only are covered under KenPAC. The recipient may choose the physician or clinic. It is especially important for the KenPAC recipient to present his/her Medical Assistance Identification Card each time a service is received.

AIS/MR: The Alternative Intermediate Services/Mental Retardation (AIS/MR) home- and community-based services project provides coverage for an array of community based services that is an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD). Community mental health centers arrange for and provide these services.

HCB: A home- and community-based services project provides Medicaid coverage for a broad array of home- and community-based services for elderly and disabled recipients. These services are available to recipients who would otherwise require the services in a skilled nursing facility (SNF) or intermediate care facility (ICF). The services were statewide July 1, 1987. These services are arranged for and provided by home health agencies.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

HOSPICE:

Medicaid benefits include reimbursement for hospice care for Medicaid clients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance are also provided to the patient and his/her family in adjustment to the patient's illness and death. A Medicaid' client who elects to receive hospice care waives all rights to certain Medicaid services which are included in the hospice care scope of benefits.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

ELIGIBILITY INFORMATION

Programs

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

AFDC (Aid to Families with Dependent Children)

AFDC Related Medical Assistance

State Supplementation of the Aged, Blind, or Disabled

Aged, Blind, or Disabled Medical Assistance

. Refugee Resettlement Programs

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits should be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office for information about making application. For most programs, a relative or other interested party may make application for a person unable to visit the office.

In addition to the programs administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) program also receive Medicaid through the Kentucky Medical Assistance Program. Eligibility for SSI is determined by the Social Security Administration. Persons wanting to apply for SSI should be referred to the Social Security Administration office nearest to the county in which they live. The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

ELIGIBILITY INFORMATION

MAID Cards

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID cards may show a retroactive period of eligibility. Depending on the individual circumstances of eligibility, the retroactive period may include several months.

Duplicate MAID cards may be issued for individuals whose original card is lost or stolen. The recipient should report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

Verifying Eligibility

The local Department for Social Insurance, Division of Field Services staff may provide eligibility information to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

MAP-343 (Rev.5/86)

Provider Number: _____
(If Known)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT; made and entered into as of the ____ day of _____, 19__, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services.; hereinafter referred to as the Cabinet, and _____
(Name of Provider)

_____
(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department. for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations .and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

_____
(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this. agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

(4) Agrees to maintain such records as are necessary to disclose the extent of services furnished to Title XIX.recipients for a minimum of 5 years and for such additional time as may be necessary in the event of an audit exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.)

(6) Assures that he (it) is aware of Section 1909 of the Social Security Act; Public Law 92-603 (As Amended), reproduced on the reverse side of this Agreement and of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 205.990 relating to medical assistance fraud.

(7) Agrees to inform the Cabinet for Human Resources, Department for Medicaid Services, within 30 days of any change in the following:

(a) name;
(b) ownership;
(c) licensure/certification/regulation status; or
(d) address.

(8) Agrees not to discriminate in services rendered to eligible Title XIX recipients on the basis of marital status.

(9) (a) In the event that the Provider is a specialty hospital providing services to persons aged 65 and over, home health agency, or a skilled nursing facility, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the event that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hospitals. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

(10) In the event that the provider desires to participate in the physician or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicians' or dentists' services provided to recipients of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed physician or dentist of a Staterent of Authorization (MAP-347).

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Fledical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with current applicable federal and state laws, rules and regulations and policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

3. Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19__, with conditional termination on _____, 19__, and shall automatically terminate on _____, 19__, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

PENALTIES

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than 510,000 or imprisoned for not more than one year, or both. 'In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligfbility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or 'in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good. facility, service, or item for which payment may be made in whole or in part under this title,,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than 525,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebatej directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, cr ordering any good, facility, service, or item for which payment may be made in whole or in part under' this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than 525,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount othemise require4 to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (le who e or in part: under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not nore than five years, or both.

MAP-344 (Rev. 08/85)

KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Information

1. Name: _____

2. _____
Street Address, P.O. Box, Route Number (In Care of, Attention, etc.)

3. _____ _____ _____
City State Zip Code

4. _____
Area Code Telephone Number

5. _____
Pay to, In Care of, Attention, etc. (If different from above)

6. _____
Pay to Address (If different from above)

7. Federal Employer ID Number: _____

8. Social Security Number: _____

9. License Number: _____

10. Licensing Board (If Applicable): _____

11. Original License Date: _____

12. KMAP Provider Number (If Known): _____

13. Medicare Provider Number (If Applicable): _____

14. Provider Type of Practice Organization:

/_/ Corporation (Public) /_/ Individual Practice /_/ Hospital-Based Physician

/_/ Corporation (Private) /_/ Partnership /_/ Group Practice

/_/ Health Maintenance Organization /_/ Profit /_/ Non-Profit

15. If group practice, Number of Providers in Group (specify provider type):

_____

16. If corporation, name, address and telephone number of Home Office:

Name: _____

Address: _____

_____

Telephone Number: _____

Name and Address of Officers:

_____

_____

_____

_____

_____

17. If Partnership, name and address of Partners:

_____

_____

_____

_____

_____

18. National Pharmacy Number (If Applicable): _____
(Seven-Digit Number Assigned by National Pharmaceutical Association)

19. Physician/Professional Specialty:

1st _____

2nd _____

3rd _____

20. Physician/Professional Specialty Certification:

1st _____

2nd _____

3rd _____

21. Physician/Professional Specialty Certification Board:

1st _____ Date: _____

2nd _____ Date: _____

3rd _____ Date: _____

22. Name of Clinic(s) in Which Provider is a Member:

1st _____

2nd _____

3rd _____

4th _____

23. Control of Medical Facility:

☐ Federal ☐ State ☐ County ☐ City ☐ Charitable or Religious

☐ Proprietary (Privately owned) ☐ Other _____

24. Fiscal Year End: _____

25. Administrator: _____ Telephone No. _____

26. Assistant Administrator: _____ Telephone No. _____

27. Controller: _____ Telephone No. _____

28. Independent Accountant or CPA: _____ Telephone No. _____

29. If sole proprietorship, name, address, and telephone number of owner:

Name: _____

Address: _____

Telephone No. _____

30. If facility is government owned, list names and addresses of board members:

	Name	Address
President or Chairman of Board:		
Member:		
Member:		
Member:		
Member:		

31. **Management Firm** (If Applicable):

Name: _____

Address: _____

32. Lessor (If Applicable):

Name: _____

Address: _____

33. Distribution of Beds in Facility (Complete for all levels of care):

	Total Licensed Beds	Total Title XIX Certified Beds
Hospital Acute Care		
Hospital Psychiatric		
Hospital TB/Upper Respiratory Disease		
Skilled Nursing Facility		
Intermediate Care Facility		
ICF/MR/DD		
Personal Care Facility		

34. SNF, ICF, ICF/MR/DD Owners with 5% or More Ownership:

Name	Address	Percent of Ownership

35. Institutional Review Committee Members (If Applicable):

_____

_____

_____

_____

_____

36. Providers of Transportation Services:

No. of Ambulances in Operation: No. of Wheelchair Vans in Operation: _____

Total No. of Employees: _____ (Enclose list of names, ages, experience & Training.)

Current Rates:

A. Basic Rate $_____ (Includes up to _____ miles.)

B. Per Mile $_____

C. Oxygen $_____

D. Extra Patient $_____

E. Other _____ $_____

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute,-medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medical-Assistance Program.

Signature: _____

Name: _____

Title: _____ Date: _____

INTER-OFFICE USE ONLY

License Number Verified through _____ (Enter Code)

Comments: _____

_____

Date: _____ Staff: _____

MAP-346
(8/82)

KENTUCKY MEDICAL ASSISTANCE PROGRAM
CERTIFICATION OF CONDITIONS MET
FACILITY-BASED MEDICAL PROFESSIONALS REMUNERATION
AS AN ELEMENT OF FACILITY'S REIMBURSABLE COST

This is to certify that each of the following named licensed medical professionals is currently entered into financial arrangements with _____ (Facility Name) _____, (City) (State) for the purpose of rendering his/her special services to patients of this facility, and that currently on file in this care center is a Statement of Authorization executed by each of these individuals which authorizes payment by the KMAP to the _____ (Facility Name) for services rendered eligible Program beneficiaries.

NAME	LICENSE NUMBER	POSITION (Physician, Psychiatrist, etc.)	DATE OF CENTER EMPLOYMENT

Signed _____
Facility Administrator

MAP-347
(02/86)

APPENDIX VI

KENTUCKY MEDICAL ASSISTANCE PROGRAM
STATEMENT OF AUTHORIZATION

I hereby declare that I, _____,
(Licensed Professional)

a duly-licensed _____, have entered into a

contractual agreement with _____
(Clinic/Corporation/Facility Name)

_____
(City, State, & Zip Code)

, to provide professional services. I authorize payment to

_____
(Clinic/Corporation or Facility Name)

from the Kentucky Medical Assistance Program for covered services provided by me and specified by the criteria of our contract. I understand that I, personally, cannot bill the Kentucky Medical Assistance Program for any service that is

reimbursed to _____
(Clinic/Corporation or Facility Name)

as part of our contractual agreement, and that I am solely and completely responsible for all Kentucky Medical Assistance Program documents submitted by this employer in my name for services I provided.

_____ _____
Signature of Professional Date Signed

_____ _____
License and/or Certification Number Specialty

_____
Social Security Number

_____
Federal Employer Identification Number

_____
KMAP Provider Number of
Clinic/Corporation or Facility

PENALTIES

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, In any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that fndividuat for such period (not exceeding one year) as it deems appropriate; but the impotitfon of a limitation, restriction, or suspension with respect to the eligibility of any individual under thfs sentence shall not affect the eligibfllfty of any other person for assistance under the plan, regardless of the relationship between that individual and such other get-son.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, brlbe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing. of any item or service for which payment may be made in whole or fn part under this title, or

(8) fn return for purchasing, leasing, ordering, or arranging far or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this tfttt.

shall be guilty of a felony and upon conviction thereof, shall be ffned not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneratiqn (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or'arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facilfty, service, or item for which payment may be made in whole or fn part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than 525,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facilfty, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than 525,000 imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provfded to a patfent under a State plan approved under this tftle, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or phflanthropfe contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursfng facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

all be guilty of a felony and upon conviction thereof shall be ffned not more than 525,000 or imprisoned for not re than five years, or both.

MAP 7 (10/86)

Do not write in this area

EDS
P.O. Box 2064
Frankfort, KY 40602

COMMONWEALTH OF KENTUCKY
MEDICAL ASSISTANCE STATEMENT

PRIMARY CARE/RURAL HEALTH

RECIPIENT LAST NAME	2. FIRST NAME	3. M.I.	4. MEDICAL ASSISTANCE I.D. NUMBER

5. ☐ IF EMERGENCY CHECK BOX	6. If Claim Required A Prior Authorization, Enter The Prior Authorization Number Here	7. If Services Were Provided As A Result of A Screening Exam Referral, Check Box	8. If Patient Was Referred To You. Enter The Name of The Referring Practitioner.
	- - -	c l	

9. IF PATIENT HAS HEALTH INSURANCE. ENTER THE NAME AND ADDRESS OF COMPANY AND POLICY NUMBER. — LEAVE BLANK

10. (1) FIRST DIAGNOSIS:

(2) SECOND DIAGNOSIS:

11. INDICATE SERVICE BY ENTERING APPROPRIATE CODE (SEE MANUAL)

- ☐ General Health Assessment and Patient History
- ☐ Development Assessment
- ☐ Visual Screening
- ☐ Audiometric Screening
- ☐ Dental Screening
- ☐ Urinalysis
- ☐ Tuberculosis Test
- ☐ Hematocrlt or Hemoglobin
- ☐ Lead Poisoning
- 0 Other (Specify)

12. INDICATE SPECIAL TESTS BY ENTERING APPROPRIATE CODE (SEE MANUAL)

- ☐ Assessment and Administration of Vaccines and Immunizations
- ☐ Blood Pressure
- ☐ V.D.R.L.
- ☐ Sickle Cell Test
- ☐ Bacteriuria Screening
- ☐ Other (Specify)

13. INDICATE, CATEGORY OF SERVICE

Primary
410 Cafe Center

Other
☐ (Enter Code)

14. REFERRED TO:

01 ☐ PHYSICIAN 02 ☐ DENTIST ☐ OTHER (SPECIFY) _____

15. DISPOSITION OF CASE: A ☐ NORMAL VISIT SCHEDULED B ☐ REFERRED FOR TREATMENT

• Line No.	17. Provider Number	16. Place of Service Note (1)	19. Procedure/Supply Description PRESCRIPTION NUMBER	20. Drug Number	21. Units of Service	22. Procedure Supply Code	23. 24. Tooth ID	see Note (2)	25. Procedure Charge	26. LEAVE BLANK
02										
03										
04										
05										
06										
07										
08										
09										
10										

30. PROVIDER NAME AND ADDRESS

31. Provider Number

TOTAL CLAIM CHARGE	27.	39. LEAVE BLANK
AMOUNT FROM HEALTH INSURANCE	28.	
AMOUNT FROM MEDICARE	29.	

32. Authorized Certification and Signature

This is to certify that the foregoing information is true. accurate. and complete and that any subsequent transactions which alter the information contained therein will be reported to the Kentucky Medical Assistance Program. I understand that payment and satisfaction of this claim will be from Federal and State funds, and thay any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

33. COUNTY 34. AREA

35. INVOICE DATE Mo. Day Yr.

38. INVOICE NO. 0543758

36. Oate of Service Mo. Day Yr.

NOTE (1) PLACE OF SERVICE CODES
1. Doctor's Office
2. Patient's Home
3. Outpatient Dept. Hospital
4. Inpatient Hospital
5. Skilled Nursing Home
6. Primary Care Center
7. Intermediate Care Facility
8. Independent Laboratory
9. Rural Health Clinics/HMO

NOTE (2) Enter Diagnosis Treated from Block 10 "1" First "2" Second

37. CHARGE DISPOSITION
☐ Pay
☐ Charge
Accumulate

MAP-251
(Rev.1 2/86)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
Department for Medicaid Services

HYSTERECTOMY CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO HAVE A HYSTERECTOMY WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

I, _____ , have requested and received information-about
(print or type / patients name)

hysterectomies (abdominal and/or vaginal) from _____ .
(name of attending physician)

I was informed that a hysterectomy is the surgical removal of the uterus/womb and of the two (2) methods of performing the procedure (abdominal hysterectomy and vaginal hysterectomy).

I have been advised of the type of hysterectomy procedure (abdominal and/ or vaginal) that will be performed on me. I am aware of the complications that may result from the performance of this surgical procedure.

I was informed that a hysterectomy is intended to. be a permanent/final and irreversible procedure. I understand that I will be unable to become pregnant or besr children.

I certify that I fully understand the above and voluntarily consent to the surgical procedure.

Signature of Patient/
Representative _____

Signature of Person
Obtaining Consent _____

Date _____

Completion of "Hysterectomy Consent Form," MAP-251

1. Purpose

Federal regulations (42 CFR 441.250-441.258) require any individual receiving a hysterectomy to read and sign a federally approved consent form with information about the procedure and the results of the procedure. Form MAP-251 or another form approved by the Secretary of Health and Human Services, provides that documentation and must be signed by the individual receiving the hysterectomy or her representative, except in circumstances described in Section IV of this manual.

2. General Instructions

The "Hysterectomy Consent Form" (MAP-251) is a 5-part self-carbonized form.

All blanks must be completed.

The following individuals or offices should receive a copy of the completed MAP-251 form:

- the surgeon, to attach to the primary care center's claim form;
- the assistant surgeon, to attach to the assistant surgeon's claim form;
- the anesthesiologist, to attach to the anesthesiologist's claim form;
- the hospital, to attach to the hospital claim form; and
- the patient or her representative, for her records.

Additional copies of the completed MAP-251 form may be made for documentation purposes, if necessary.

Attach the signed and dated form MAP-251 behind the corresponding claim form and submit for processing. When a hysterectomy is performed on an individual who is already sterile, or who required a hysterectomy because of a life-threatening emergency, attach the physician's written certification behind the claim form and submit for processing.

Order MAP-251 forms from:

Department for Medicaid Services
CHR Building, 3rd Floor East
275 East Main Street
Frankfort, KY 40621

Attention: Jim Garrison

3. Detailed Instructions for Completion of the Form

Enter the name of the patient.

Enter the name of the physician providing information about the hysterectomy.

The patient or her representative reads and signs the form.

The person obtaining consent signs and dates the form.

The dates cannot be after the date of the surgery.

MAP-250
(R E V . 5/87)

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

Press firmly to assure legible copies

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation. have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the' withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I, _____ hereby consent of my own free will to be sterilized by _____ (doctor)

by a method called _____. My consent expires 180 days from the date of niy signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or

Empkyees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date: _____
Signature Month Day Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian Or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Interpreter Dare

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ (name of individual) signed the consent form. I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is. different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 2 1 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
Signature of person obtaining consent Date

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on _____ (Date of sterilization), I explained to him/her the nature of the operation sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 2 1 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final pamgmphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
- ☐ Individual's expected date of delivery:
- ☐ Emergency abdominal surgery:

(describe circumstances):

_____
Physician

Date _____

3. State Agency, Program or Project

Completion of "Consent Form," MAP-250

1. Purpose

Federal regulations (42 CFR 441.250-441.258) require any Individual being sterilized to read and sign a federally approved consent form with information about the procedure and the results of the procedure. Form MAP-250, "Consent Form" or another form approved by the Secretary of Health and Human Services, provides that documentation and must be signed by the recipient, the person obtaining the consent, and the physician according to Program policy. Refer to Section IV for Program policies pertaining to sterilizations.

2. General Instructions

The "Consent Form" (MAP-250) is a 5-part self-carbonized form.

All blanks must be completed.

The following individuals or offices should receive a copy of the completed MAP-250 form:

- the surgeon, to attach to the rural health clinic's claim form;
- the assistant surgeon, to attach to the assistant surgeon's claim form;
- the anesthesiologist, to attach to the anesthesiologist's claim form;
- the hospital, to attach to the hospital claim form; and
- the patient.

Additional copies of the completed MAP-250 form may be made for documentation purposes, if necessary.

Attach the signed and dated form MAP-250 behind the corresponding claim form and submit for processing.

Order MAP-250 forms from:

Department for Medicaid Services
CHR Building, 3rd Floor East
275 East Main Street
.-Frankfort, KY 40621

Attention: Jim Garrison

3. Detailed Instructions for Completion of Form

a. Consent *to* Sterilization

This section must be completed at least 30 days prior to the sterilization procedure, except in cases of premature delivery and emergency abdominal surgery, in which cases a 72-hour waiting period is required. No more than 180 days may elapse between the date the form is signed and the date the procedure is performed.

Enter the name of the physician, clinic or the name of the physician and the phrase "and/or his/her associates" who expects to perform the procedure.

Enter the name of the procedure to be performed.

Enter the birthdate of the patient.

Enter the name of the patient.

Enter the name of the physician expected to perform the procedure.

Enter the method of sterilization.

The patient signs the form.

Enter the date the patient signs the form.

Race and ethnicity information may be designated by checking the appropriate block.

b. Interpreter's Statement

If appropriate, complete this section at the same time the above section is completed.

Enter the language used to read and explain the form.

The interpreter signs and dates the form.

c. Statement of Person Obtaining Consent

This section is completed at the same time or after the above two sections are completed.

Enter the patient's name.

Enter the procedure name.

The person obtaining the consent reads, signs, and dates the form. This date must be on or after the date the patient signed.

Enter the name and address of the rural health clinic employing the person obtaining consent.

d. Physician Statement

This section is completed at the same time or after the procedure is performed.

Enter the name of the patient and the date of the sterilization.

Enter the procedure performed.

Follow instructions on the form. Cross out the paragraph not used.

If the sterilization was performed less than 30 days but more than 72 hours after date of the individual's signature on the Consent Form, check the applicable block and provide the information requested.

In the case of premature delivery, enter the expected date of delivery. The expected date of delivery must be at least 30 days after the individual's signature date.

If the procedure was performed as a result of emergency abdominal surgery, enter a brief description in the designated area of the Consent Form, or attach an operative report to describe the circumstances as required.

The physician who performed the procedure signs the form. The actual signature of the physician is required.

Enter the date the physician signs the form. This date must be on or after the date of the surgery.

CERTIFICATION FORM FOR INDUCED ABORTION
OR INDUCED MISCARRIAGE

I, _____, certify that on the basis of
(Physician's Name)

my professional judgement, the life of _____
(Patient3 Name)

_____ of _____
(MAID #) *(Patient's Address)*

would be endangered if the fetus were carried to term. I further certify that the following procedure(s) was medically necessary to induce the abortion or miscarriage.

(Please indicate date and the procedure thawas performed.) _____

_____

_____

_____
Physician's Signature

_____
Name of Physician

_____
License Number

_____
Date

MAP-235 (8-78)

CERTIFICATION FORM FOR INDUCED PREMATURE BIRTH

I, _____ , certify that on the basis of
(Physician's Name)

my professional judgement, it was necessary to perform the following procedure on _____
(Date)

to induce premature birth intended to produce a live viable child. _____
(Procedure)

This procedure was necessary for the health of _____
(Name of Mother)

_____ of _____
(MAID #) *(Address)*

and/or her unborn child.

_____
Physician's Signature

_____
Name of Physician

_____
License Number

_____
Date

DSS-115
R.7/87

APPENDIX XI

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL SERVICES

CONFIDENTIAL
SUSPECTED ABUSE/NEGLECT, DEPENDENCY OR EXPLOITATION REPORTLNG FORM

TYPE REPORT: ☐ Child ☐ Adult ☐ Spouse County of Report _____ Time Report Received _____

Report Date _____ Incident Date(s) _____

1. Name(s)	Age	Sex	Nature of Report
a. _____	____	____	☐☐☐☐
b. _____	____	____	☐☐☐☐
c. _____	____	____	☐☐☐☐
d. _____	____	____	☐☐☐☐
e. _____	____	____	☐☐☐☐

CHILD ADULT

1. Physical Injury
2. Sexual Abuse
3. Mental Injury
4. Neglect
5. Dependency

6. Adult Abuse
7. Spouse Abuse
8. Self-Neglect
9. Caretaker Neglect
10. Exploitation

2. Current Address _____
Street/Rural Route City/Zip County Telephone #

3. Directions _____

4. Parent(s) /Guardian/Caretaker _____ Relationship _____

5. Other Known Household Members _____

6. Describe nature/extent/causes of abuse/neglect/dependency, or exploitation. List witnesses and/or collateral contacts, previous incidents or reports. Describe behavior of adult victim and of alleged perpetrator (dangerous?)

_____

_____

_____

_____

7. Alleged Perpetrator, if **different** from 4 above

Name _____ Relationship _____

Address _____
Street/Rural Route City/Zip County Telephone #

8. Person Taking Report _____ Title _____

9. Worker Assigned to Investigate _____ County _____ Telephone # _____

by: Family Services Office Supervisor _____

10. ATTENTION: LAW ENFORCEMENT ☐ Certification of Receipt of Report on Form JC-3 or by Other Law Enforcement Means.

Kentucky Revised Statutes, Chapter 620.030 and/or 209.030(2), dealing with suspected child physical or sexual abuse and suspected adult abuse, neglect, exploitation, or spouse abuse requires the Department for Social Services to notify the appropriate law enforcement agency.

INTERVENTION REQUESTED0 ☐ At your discretion

c l Sent to: _____ , County Attorney

Person Making Report _____ Title/Relationship _____

Address _____
Street/Rural Route City/Zip county Telephone #

TRANSMITTAI #12

TRANSMITTAL #12

AS OF 07/06/87 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT Page 1

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: RURAL HEALTH SERVICES

* PAID CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
0231046	DONALDSON R	4834042135	9883324-552-580	111786	60.00	0.00	40.00	379
01 POS 9	PROCEDURE 90050				40.00		40.00	952
02 RX NO.	086510 DRUG CODE 0000300682				10.00		0.00	300
03 POS 9	PROCEDURE 81000				10.00		0.00	300

CLAIMS PAID IN THIS CATEGORY: 1 TOTAL BILLED: 60.00 TOTAL PAID: 40.00

APPENDIX XII-A

TRANSMITTAL #12

AS OF 07/06/87 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: RURAL HEALTH SERVICES

* DENIED CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	EOB
023104	JONES R	4834042135	9883324-552-010	111786	30.00	236
01 POS 9	PROCEDURE 11122				30.00	236

CLAIMS DENIED IN THIS CATEGORY: 1 TOTAL BILLED: 30.00

APPENDIX XII-B

TR ANSMITTAL #12

AS OF 07/06/87 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT Page 3

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: RURAL HEALTH SERVICES

* CLAIMS IN PROCESS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	EOB
5713841	JOHNSON P	8032450731	9883324-552-060	110286	32.09	058
5746322	MITCHELL J	4324180114	9883324-552-020	110186	24.00	058

CLAIMS PENDING IN THIS CATEGORY: 2 TOTAL BILLED: 56.00

ATTACHMENT 2.11-C

TRANSMITTAL #12

AS OF 07/06/87 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: RURAL HEALTH SERVICES

* RETURNED CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE,	EOB
3247891		4838021143	9883324-552-060	110486	999

TOTAL CLAIMS RETURNED IN THIS CATEGORY: 1

CLAIMS PAYMENT SUMMARY

	CLAIMS PAID/DENIED	CLAIMS PD AMT.	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	2	40.00	0.00	40.00	0.00	40.00
YEAR-TO-DATE TOTAL	36	1340.00	50.00	12p.00	0.00	1290.00

APPENDIX XII-D

TRANSMITTAL #12

AS OF 07/06/87 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER PROVIDER NAME
RA SEQ NUMBER 2 PROVIDER NUMBER

CLAIM TYPE: RURAL HEALTH SERVICES

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

058	CLAIM STILL IN PROCESS
236	PERFORMING PROVIDER NOT ASSOCIATED WITH THE BILLING PROVIDER
250	THIS RECIPIENT IS NOT ON OUR ELIGIBILITY FILES
300	SERVICE PAYS ZERO FOR PRIMARY CARE AND RURAL HEALTH CLAIMS
379	PAID BY MEDICAID .
952	REIMBURSEMENT FOR THIS SERVICE IS INCLUDED IN THE TOTAL PAYMENT AMOUNT
999	REQUIRED INFORMATION NOT PRESENT

APPENDIX XII-E

PROVIDER INQUIRY FORM

EDS
P.O. Box 2009
Frankfort, Ky. 40602

Please remit both copies of the Inquiry Form to EDS.

1. Provider Number	**3. Recipient Name (first, last)**	
2. Provider Name and Address	**4. Medical Assistance Number**	
	5. Billed Amount	**6. Claim Service Date**
	7. RA Date	**8. Internal Control Number**

9. Provider's Message

10. _____
Signature **Date**

Dear Provider:

This claim has been resubmitted for possible payment.

EDS can find no record of receipt of this claim. Please resubmit.

This claim paid on _____ in the amount of _____

_____ We do not understand the nature of your inquiry. Please clarify.

EDS can find no record of receipt of this claim in the last 12 months.

_____ This claim was paid according to Medicaid guidelines.

This claim was denied on _____ for EOB code _____

_____

Aged claim. Payment may not be made for services over 12 months old **without** proof that the claim was received by EDS within one year of the date of service; and if the claim rejects, you must show timely receipt by EDS within 12 months of that rejection date. Claims must be received by EDS every 12 months to be considered for payment.

Other: _____

_____

_____

_____

_____

_____
EDS **Date**

MAIL TO: EDS FEDERAL CORPORATION
P.O. BOX 2009
FRANKFORT, KY 40602

ADJUSTMENT REQUEST FORM

1. Original Internal Control Nunber (I.C.N.)	EDS FEDERAL USE ONLY	
2. Recipient-Nane	3. Recipient Medicaid Nunber	
4. Provider Name/Number/Address	5. From Date Service	6. To Date Service
	7. Billed Amt.	8. Paid Amt. / 9. R.A. Dat

10. Please specify WHAT is to be adjusted on the claim.

11. Please specify REASON for the adjustment request or incorrect original claim payment.

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

12. Signature 13. Date

EDSF USE ONLY--DO NOT WRITE BELOW MIS LINE

Field/Line:

New Data:

Previous Data:

Field/Line:

New Data:

Previous Data:

Other Actions/Remarks:

(Revised 4/88)

KENTUCKY MEDICAL ASSISTANCE PROGRAM

Drug Pre-Authorization Policies and Procedures

INTRODUCTION

The purpose of the Drug Pre-Authorization Procedure is to provide Kentucky Medical Assistance Program (KMAP) recipients with access to certain legend drugs not normally covered on the KMAP Outpatient Drug List, under the condition that provision of the drug(s) in question is expected to make an otherwise inevitable hospitalization or higher level of care unnecessary. Such requests are referred to the Program by physicians, pharmacists, and social workers. Determinations are made based on the merits of the individual request and information received.

To assist with determining the kinds of requests which can be considered for pre-authorization, the following outline of criteria and procedures has been developed for your convenience.-

I. DRUG PRE-AUTHORIZATION CRITERIA

A. Request Criteria

1. The requested drug is to be used in lieu of hospitalization to maintain the patient on an outpatient basis and/or prevent a higher level of care.

2. The requested drug must be a legend drug. The only exception will be non-legend nutritional supplements when: 1) general pre-authorization criteria are met; 2) the patient's nutrition is maintained through the use of the nutritional product; and 3) the patient would require institutional care without the nutritional supplement.

3. The requested drug is to be used in accordance with standards and indications, and related conditions, approved by the Food and Drug Administration (FDA).

4. The requested drug will not be considered for pre-authorization if it is currently classified by FDA as "less than effective" or "possibly effective."

5. Drugs on the formulary must have been tried, when appropriate, with documentation of ineffectiveness.

6. The Program will not pre-authorize the trial usage of a maintenance drug except when the drug has been tried for at least two weeks with successful results prior to the request. In such cases, when all criteria are met, retroactive pre-authorization for two weeks will be considered in addition to the usual pre-authorization period.

B. Pre-Authorization of Therapeutic Categories

Any therapeutic category may be considered for pre-authorization in accordance with the diagnosis. However, all Program criteria and guidelines must be met.

C. Guidelines For Specific Drug Categories

1. Analgesics

Requests for analgesics will be approved for cancer, AIDS, spinal cord injury, and rehabilitation patients up to a period of six months.

2. Antibiotics

Requests for antibiotics will be considered only if culture and sensitivity tests have identified specific sensitivity and/or only if drugs included on the Drug List have been tried unsuccessfully. However, if a course of treatment had been started while hospitalized, consideration will be given to the request.

3. Antitussives, "Cough Mixtures," Expectorants, Antihistamines

Requests for "cough mixture" preparations such as expectorants and antitussives will not be pre-authorized. Only specified antihistamines may be pre-authorized if all other criteria have been met.

4. Chemotherapeutic Agents

Requests for anti-neoplastic agents will be considered for approved FDA indications.

5. Hypnotics and Sedatives

Requests for sedatives and hypnotics will be considered only after covered antidepressant and/or antipsychotic drugs have been tried unsuccessfully and if hospitalization would be prevented. Also such requests must be accompanied by an appropriate psychiatric diagnosis. Hypnotics and sedatives will not be approved for more than two weeks, unless there is a diagnosis of terminal cancer.

6. Maintenance-Type Drugs

Requests for maintenance-type drugs will be considered only if such drugs have been tried for at least two weeks with successful results prior to the request and related drugs on the formulary have been unsuccessful.

7. Non-Legend Drugs

Non-legend (over-the-counter) drugs will be excluded from coverage under drug pre-authorization.

The only exception will be non-legend nutritional supplements as noted in I. A. 2. above.

a. Ophthalmics and Topical Preparations.

Requests for ophthalmics or topical preparations will not be pre-authorized unless related preparations included on the Drug List have been tried unsuccessfully, and a higher level of care would ensue without further medication.

9. Tranquilizers, Minor

Requests for minor tranquilizers will be considered only for acute anxiety, alcohol or drug withdrawal (with a one-month limitation), cancer, seizure disorders, and quadraplegia/ paraplegia.

10. Ulcer Treabnent Drugs, Legend

On the basis of ulcer symptoms, legend ulcer treatment drugs may be pre-authorized if other applicable pre-authorization criteria are met.

11. Total Parenteral Nutrition

May be pre-authorized if the need exists. Medicare maximum amounts allowed/month and maximum fees/month are applicable. The maximum amounts/fees allowed/month are subject to post payment review.

12. Transdermal Antihypertensive Medication

Transdermal antihypertensive medication may be pre-authorized without first prescribing oral forms when the prescriber certifies that the medication is certified for an elderly patient who is unable to follow directions in using oral forms of the medication.

D. Pharmacy Lock-In

The pharmacy originally selected by the recipient must remain the provider during the period of the pre-authorization unless a valid reason for change exists.

III. INFORMATION REQUIRED FOR A DETERMINATION

Persons requesting a pre-authorization of medications should provide information, line for line from the Pre-Authorization Request Form. Special attention should be given to giving a specific statement, indicating the need for the requested drug as well as previous medications tried unsuccessfully. Rural Health Clinics requesting a drug pre-authorization number should always give the provider number of the clinic as the provider and not the prescribing physician.

IV. DISPOSITION OF REQUEST

A. Nurses will review each request and make determinations on the basis of established Program criteria. Extenuating circumstances should be directed to the medical consultant.

B. If the appropriate information is received and the medication meets the Program criteria, an approval is made. However, if the request does not meet the basic criteria or if insufficient or contradictory information is provided, the request will be disapproved. Drug Pre-Authorization staff will NOT assume responsibility for calling physicians for more information. --

C. Unusual or unique situations are reviewed by consultant pharmacists, physicians, and recognized University staff.

D. When the medication is not on the KMAP Drug List and is disapproved for pre-authorization, the recipient must assume responsibility for the cost or obtain an alternative source of payment.

E. Determinations will be made daily Monday through Friday, except on holidays.

V. NOTIFICATION OF DISPOSITION

A. Notification regarding the disposition (approval or disapproval) of each pre-authorization request will be made as follows:

1. Disapprovals: When disapproved, the prescribing physician will be notified by mail. The request and reason for disapproval will be provided.

2. Approvals: Whehen approved, notification will be made by phone to the selected pharmacy. The pharmacist will provide the preauthorization staff with the NDC number and provider number.

NOTE: Pre-authorization is not guaranteed for any request until reviewed and approved by pre-authorization staff members. If any change should occur, i.e. NDC #, MAID #, quantity, etc., please notify pre-authorization staff immediately to assure Program payment.

B. Period of Coverage

The effective date for Program coverage of pre-authorized drugs will begin on the date the request is postmarked or date received by phone. Upon request, it is possible to allow up to a 10-day grace period on the beginning date. The pre-authorization will remain in effect for the specified time on 'the "Authorization to Bill" or until the recipient becomes ineligible, whichever canes first.

CAUTION: Pre-authorization does not guarantee payment.
Recipient must be eligible on date of service.
Verify by checking the recipient's Medicaid card.

VI. REIMBURSEMENT INFORMATION

A. Pre-authorized drugs will be reimbursed in the same manner as any other prescription drug entered on the MAP-7 claim form. The only addition to the claim form is the assigned pre-authorization number which is to be entered in Block #6 of the MAP-7 claim form. List the number as shown 0 0 0 0.

B. Private insurance canpanies, if applicable, must be billed prior to submitting claims for payment.

VII. ADDITIONAL INFORMATION

Any questions regarding the Drug Pre-Authorization Procedure should be directed to:

EDS
P.O. Box 2036
Frankfort, KY 40602

Telephone Number: 1-800-372-2944

Medicare Maximum Allowables for Enteral/Parenteral Home Hyperalimentation

Description	Amount Allowed	
Compleat-B (liquid), 8 oz., per 24	$ 50.60	8 per month
Magnacal (liquid), 8 oz., per 24	50.60	8 per month
Vitaneed (liquid), 355 ml., per 24	50.60	8 per month
Criticare HN (liquid), 8 oz., per 24	81.35	10 per month
Compleat Modified (liquid), 8 oi., per 24	81.35	10 per month
Isocal HCN (liquid), 8 oz., per 12	26.20	8 per month
Meritene (liquid), 8 oz., per 24	26.20	8 per month
Sustacal (liquid), 8 oz., per 24	21.44	10 per month
Ensure (liquid), 8 oz., per 24	21.44	10 per month
Ensure Plus (liquid), 14 oz., per 6	21.44	10 per month
Osmolite (liquid), 8 oz., per 24	21.44	10 per month
Renu (liquid), 250 ml., per 24	21.44	10 per month
Isocal (liquid), 8 oz., per 24	21.44	10 per month
Travasorb whole protein, any flavor (liquid), 8 oz., per 24	21.44	10 per month
Vivonex HN (powder), 80 mg., per 10	45.68	31 per month
Precision HN (powder), 87.9 mg., per 10	45.68	31 per month
Travosorb Renal (powder) gm. 112 per 5	45.68	31 per month
Sustagen (powder), 5 lb., each	34.88	7 per month
Meritene (powder), 4.5 lb., each	34.88	7 per month
Precision isotonic (powder), 61.8 gm., per	17.28	31 per month
Travasorb STD, any flavor (powder), 83.3 mg., per 6	17.28	31 per month
Travasorb MCT (powder), 89 mg., per 5	17.28	31 per month
Flexical (powder), 60 mg., per 8	14.90	31 per month
Vivonex STD (powder), 80 mg., per 6	14.90	31 per month
Precision LR (powder), 90 mg., per 6	14.90	31 per month
Intralipids (500 ml.)	36.40	31 per month
Heparin (2 cc)	30.60	Monthly Maximum
Nutrient expander (saline, 500 ml.)	5.00	31 per month
Parenteral nutrients, 1 liter/day	79.31	31 per month
Parenteral nutrients, 2 litters/day	132.00	31 per month
Sustagen (powder), 1 lb, each	10.05	31 per month
Portagen (powder), 1 lb, each	10.05	31 per month
Meritene (powder), 1 lb, each	9.58	16 per month
Sustacal (powder), 54.5 gm., per 24	9.58	16 per month
Vital HN (powder), 78 gm., per 24	76.60	7 per month
Travasorb HN (powder), 83.3 gm., per 6	32.47	31 per month

THIRD PARTY LIABILITY PROVIDER LEAD FORM

DATE:.

PROVIDER NAME: _____ PROVIDER #: _____

RECIPIENT NAME: _____ MAID: _____

BIRTHDATE: _____ ADDRESS: _____

DATE OF SERVICE: _____ T O _____ DATE OF ADMISSION: _____

DATE OF DISCHARGE: _____ NAME OF INS. CO.: _____

POLICY #: _____ CLAIM NO.: _____

AMOUNT OF EXPECTED BENEFITS: _____

MAIL TO: EDS
Fiscal Agent for KMAP
ATTN: TPL Unit
P.O. Box 2009
Frankfort, KY 40602

LABORATORY ADDENDUM

Laboratory

The following is a list of procedures covered under the Independent Laboratory Services element of the KMAP. These are payable to laboratories licensed by the state in which they operate. Laboratory services must be ordered in writing, and signed by a duly licensed staff physician, nurse practitioner or dentist, within the scope of their licensure, for the care and treatment indicated in the management of illness, injury, impairment, maternity care, or for the purpose of determining the existence of an illness or condition in a recipient. The order must be maintained within the clinic's records, including the patient's file.

Laboratory tests can not be billed to EDS for services rendered to residents of skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded and developmentally disabled, when the resident is in vendor status with the KMAP.

Procedural Coding

The coding for Laboratory procedures is found in the Health Care Financing Administration (HCFA) Common Procedural Coding System (HCPCS). The following is a list of procedures covered under the Independent Laboratory Services element of the KMAP.

Procedure	Code No.
Red Blood Count*	85041
White Blood Count*	85048
Differential*	85007; 85009
Complete Blood Count	85021; 85022; 85028; 85031
Cholesterol	82465
Clotting Time	85345; 85347
Hematocrit*	85014
RA Test (Latex Agglutinations)	86430
Acid Phosphatase	84060
Alkaline Phosphatase	84075; 84078

*CBC procedure should be coded when billing three or more of the tests indicated by asterisk.

LABORATORY ADDENDUM

Procedure	Code No.
Platelet Count	85580; 85585; 85590; 85595
Potassium	84132
Hemoglobin*	85018
Prothrombin Time	85610; 85612; 85614
Sedimentation Rate	85650; 85651
Sodium	84295
Glucose (Blood)	82947; 82948; 82949
SGOT or SGPT (Serum Transaminase)	84450; 84455; 84460; 84465
Blood Typing	86080; 86082; 86090; 86105; 86115; 86120
Blood Urea Nitrogen	84520; 84525; 84540
Uric Acid	84550
Stool (Occult Blood)	82270
Pap Smear	88150
Urine Analysis	81000
Urine Culture	87086; 87087; 87088
Sensitivity Testing	87181; 87184; 87186; 87188; 87190
Pregnancy Test	82996; 82997
CPK/Creatine	82540; 82545; 82550
Thyroid Profile	80070
T3	84479; 84480; 84481
T4	84435; 84436; 84437; 84439
Glucose Tolerance	82951, W8724, 82952
Rubella	86171
Therapeutic Drug Monitoring	80031; 80032, 80033; 80034; 80040
Lithium	83725
Theophylline	84420
Digoxin	82643
Digitoxin	82640; 82641
Electrolytes	80003; 80004; 80005; 80006; 80007; 80008; 80009; 80010; 80012; 80016, 80018; 80019
Dilantin/Phenobarbital/Drug Abuse Screen	82205; 82210; 82660
Arthritis Profile	80002; 80003
VDRL	86592

*CBC procedure should be coded when billing three or more of the tests indicated by asterisk.

LABORATORY ADDENDUM

Procedure	Code No.
Any 3 Automated Tests	80003
Any 4 Aufomated Tests	80004
Any 5 Automated Tests	80005
Any 6 Automated-Tests	80006
Any 7 Automated Tests	80007
Any 8 Automated Tests	80008
Any 9 Automated Tests	80009
Any 10 Automated Tests	80010
Any 11 Automated Tests	80011
Any 12 Automated Tests	80012
Any 13-16 Automated Tests	80016
Any 17-18 Automated Tests	80018
Any 19 or More Automated Tests	80019

FAMILY PLANNING SERVICES ADDENDUM

Family Planning

1. Initial Visit

a. **Complete** Medical History--A complete medical history shall be **obtained** and recorded and shall include, but not be limited to:

1) Complete obstetrical history, with menarche and menstrual history, last menstrual period, gravidity, parity, pregnancy outcomes, and complications of any pregnancy and/or delivery.

2) Any significant illnesses, hospitalizations, and previous medical care and the indicated systems review, e.g., cardiovascular, renal, **neurologic,** hepatic, endocrine, hematologic, gynecologic (Dysmenorrhea, metrorrhagia, menorrhagia, post-coital bleeding, vaginal discharge, dyspareunia) and venereal disease.

3) Previous contraceptive devices or techniques used, and problems related to their use.

4) Present and past physical conditions **which** might influence choice of contraceptive method, to include:

a) Thromboembolic disease
b) Hepato-renal disease
c) Breast and/or genital problems
d) Diabetic and pre-diabetic conditions
e) Cephalgia and migraine
f) Hematologic phenomena
g) Pelvic inflammatory disease

5) Relevant family health history, including significant recurrent chronic illness, genetic aberrations, and unusual health factors among family members.

6) Relevant psychiatric history, including previous history of mental depression.

7) Social history.

b. Physical Examination - The initial examination shall include:

1) Thyroid palpation

2) Inspection and palpation of breasts and axillary glands, with instructions to the patient for self-examination

3) Auscultation of heart

4) Auscultation of lungs if respiratory symptoms present

5) Blood pressure

6) Weight and height

7) Abdominal examination

8) Pelvic examination, including speculum, bimanual, and rectovaginal examinations

9) Extremities

10) Others as indicated

c. Laboratory and Clinical Tests--The recipient shall receive at least the following laboratory and clinical tests.

1) Hematocrit or hemoglobin

2) Urinalysis for sugar and protein

3) Papanicolaou smears

4) Culture for N gonorrhea

5) Serology for syphilis*

d. Information and Education Regarding Contraceptive Methods--The recipient shall be given comprehensive, detailed information concerning reversible and irreversible contraceptive methods available. This information shall include mode of action, advantages and disadvantages, effectiveness, and common side effects of each method. Basic information concerning venereal disease shall also be given.

At the outset of the discussion, the recipient's level of knowledge regarding reproductive functions shall be established and basic information presented where necessary.

Ample time shall be given for the recipient to ask pertinent questions and to relate the presented information to his/her personal situation.

*ONLY WHEN MEDICALLY INDICATED

e. Prescription of Contraceptive Method--The physician shall prescribe the contraceptive method, based on the medical and psychiatric history, the medical examination, laboratory tests, and the recipient's wishes. The physician or the registered nurse shall give complete verbal instructions as to use of the method, and the recipient shall also be given complete written instructions.

ARNP limitations will be based on the written protocols as they relate to the specific contraceptive method.

ALL OF THE PRECEDING SERVICES MUST BE COMPLETED AND DOCUMENTED BEFORE BILLING FOR AN INITIAL EXAMINATION. This will be monitored through post-payment review. Each client is limited to one initial visit per provider per lifetime.

NOTE: Limitations on Birth Control Medications

1. The Program will reimburse for no more than one prescription per day for birth control medication per Medicaid recipient.

2. The Program will reimburse for no more than a total of 13 prescriptions in any calendar year for a given Medicaid patient.

3. Through the Program's Drug Utilization Review (DUR) subsystem, an in-depth review will be accomplished in any instance where a Medicaid recipient is receiving more than the appropriate amount of birth control medication (i.e., exceeds a thirty (30) day supply in a thirty (30) day period). The purpose of the review will be to determine the reason of the excess supply, and to recommend appropriate action to address the excess supply.

2. Revisits by Contraceptive Patients

Subsequent visits to the clinic shall be scheduled at least annually and in accordance with the contraceptive method prescribed.

a. Oral Contraceptive Recipients shall return to the clinic not later than three months after the initial prescription is issued, and thereafter as indicated, or at least annually.

During the first scheduled follow-up visit, at least the following services shall be provided:

1) An interim history, to include pain (especially in the arms and chest), headaches and visual problems, mood changes, leg complaints, vaginal bleeding and/or discharge, and VD history
2) Review of menstrual history
3) Blood pressure, weight check
4) Laboratory tests as indicated

b. I.U.D. Recipients shall return to the clinic not later than three months following insertion of the device, at which time the following services shall be provided:

1) A repeat pelvic examination with visual inspection of the cervix
2) Blood pressure and weight
3) Menstrual history review
4) Review of abdominal symptoms, fever, vaginal bleeding/discharge
5) Laboratory tests as indicated

c. Diaphragm Recipients shall be seen within two to four weeks after initial fitting, to assure that the recipient can insert, position, and remove the diaphragm correctly.

d. Rhythm Method--Recipients using the rhythm method shall be seen in one month after initial visit, for instruction and assessing complaints, and six months thereafter, for review of menstrual calendar and temperature charts.

e. Other--Recipients using other methods of contraception do not require a routine follow-up visit for medical review or examination prior to the required annual visit;

3. Annual Visits

Annual visits are required for all contraceptive recipients. During these visits, at least the following services shall be provided:

a. Interim health history to update all medical and psychiatric information required in the initial history.

b. Complete physical examination, by the physician or ARNP, including all procedures required during the initial physical exam.
c. Repeat of initial laboratory and clinical procedures detailed in Section l.c., page 3.
d. Evaluation of use of current method of contraceptive and change in prescription when indicated. 'Any change shall be based on interim medical and psychiatric history, physical examination and laboratory tests, and the recipient's satisfaction and success with the current' method.
e. Complete verbal and written instructions if prescription is changed.

NOTE: Annual exams are limited to one per nine months.

6. Sterilization Counseling

Counseling services involving transmittal of complete information regarding male and/or female sterilization procedures shall be provided the individual or couple requesting such services, plus full information concerning alternate methods of contraception. These counseling services shall be provided by the physician, the advanced registered nurse practitioner and shall meet at least the following conditions:

a. The recipient's level of knowledge regarding reproductive functions shall be assessed, and proper instruction given where needed.
b. A full discussion of reversible contraceptive methods shall be given.
c. The recipient shall be made fully aware that the sterilization procedure will most likely be irreversible.
d. Sterilization procedures shall be explained in detail, with use of charts or body models.
e. The recipient shall be given complete information concerning possible complications and failures.
f. The relative merits of male versus female sterilization shall be discussed with both partners, if both are available.
g. The recipient shall be given information relating to the fact that sterilization does not interfere with sexual function or pleasure.
h. The function of the counselor is to provide information, and he/she shall in no way seek to influence the recipient to be sterilized.

FAMILY PLANNING SERVICES ADDENDUM

The following conditions shall be considered contraindications for voluntary sterilization:

a. The recipient has physical, mental, or emotional conditions which could be improved by other treatment.
b. The recipient is suffering from temporary economic difficulties which may improve.
c. The recipient or couple feel that they are not yet ready to assume the responsibilities of parenthood.
d. The recipient expresses possible wish to reverse the procedure in case of a change of circumstances.

If sterilization is not desired, alternate methods of contraception shall be discussed.

See Section IV, pages 4.6-4.8 for requirements related to sterilization procedures.

7. Infertility Services

Provision shall be made for screening and diagnosis of fertility problems. Recipients requesting infertility services shall receive complete physical exam and history, shall be given full information concerning reproductive functions, available tests and possible remedial procedures, and shall be referred to and accepted by a medical provider who can make available at least the following services:

a. Complete history and physical examinations of both partners.
b. G.C. and serologic testing of both partners.
c. Basal body temperature monitoring.
d. Semen analysis.
e. Cervical mucus examination.
f. Vaginal smear for assessment of estrogen production.
g. Endometrial biopsy.
h. Hysterosalpingogram.

a. Vaginal Infections

The clinic shall be responsible for diagnosis and treatment or referral of recipients suffering from vaginal infections.

9. Emergency Services

Provision shall be made for handling emergencies related to contraceptive services when the clinic is not in session.

10. Pregnancy Testing

The clinic shall provide pregnancy testing on request by the recipient, when indicated by the history or physical examination, or when the prescribed method of contraception would indicate need for same.

11. Referrals

The clinic shall be responsible for referral to the proper resource in the following circumstances, and for ensuring that the recipient is accepted by the resource to which he/she is referred.

a. Medical problems indicated by history, physical examination, or laboratory or clinical test.
b. For pregnancy related services when appropriate.
c. For social case work not appropriately handled by agency personnel.
d. For abortion counseling.

12. Supplies

The family planning agency shall make available to the recipient, on a continuing basis where applicable, at least the following contraceptive supplies:

a. Oral cotitraceptives
b. Intrauterine devices
c. Diaphragms
d. Foams
e. Thermometers for rhythm method
f. Jellies and Creams
g. Condoms

13. Medical Records

The family planning agency shall maintain complete recipient medical records, which shall contain but not be limited to the following:

a. Initial and interim histories -- medical, psychiatric, and social.

b. Record of initial and interim physical examinations.

c. All laboratory reports.

d. Description of each visit, to include services provided, supplies dispensed, and progress notes (recipient response to service or to contraceptive method).

e. Record of all referrals made, to include reason for referral, source to whom recipient was referred, and any information obtained as a result of referral.

f. Record of any follow-up by outreach or other agency staff outside clinic setting.

14. Availability of Services

Services of the family planning agency shall be available to each and every person requesting same, regardless of sex, race, age, income, number of children, marital status, citizenship or motive.

HCPCS Local Family Planning Services
Procedure/Supply Codes

	Physician/Advanced Registered Nurse Practioner					Registered Nurse		LPN
Type of Contraceptive Dispensed - This Visit	Intake or Initial visit	Medical Revisit or Follow-up Visit With Pelvic Examination	Medical Revisit or Follow-up visit Without Pelvic Exam.	Supply and Counseling Visit	Annual Revisit and Examination	Supply and Counseling Visit	Supply	Supply and Counseling visit
Birth Control Pills	**x1110**	x1210	x1310	**X1410**	**X1510**	X2410		
Intrauterine Device	x1120	x1220	X1320	X142.0	x1520	--	--	--
Diaphram	x1130	X1230	x1330	x1430	x1530	--	--	--
Foam/Condoms	x1140	X1240	x1340	x1440	x1540	X2440	X0024	x3440
Rhythm	x1150	x1250	x1350	x1450	x1550	X2450	X0025	x3450
Injection	x1170	X1270	x1370	x1470	x1570	--	--	--
Referral for Sterilization	**X1180**	X1280	,X1380	X 1480	X1580	X2480	--	--
Other(Specify)	**x1190**	x1290	x1390	x1490	x1590	x2490	x0029	**X3490**
None Dispensed This Visit	**x1100**	x1200	x1300	x1400	x1500	X2400	--	x3400

EPSDT ADDENDUM

SCREENING - EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are available to all recipients from birth through age 20 who are.patients of the rural health clinic, or who are accepted by the clinic as patients for EPSDT, following referral from another source (i.e. Department for Social Insurance, Department for Social Services, Local Health Department Outreach Unit, local schools, etc.).

1. The early and periodic screening services shall be under the direction of a duly-licensed physician, nurse practitioner, or registered professional nurse currently licensed by the state of Kentucky who shall be responsible for assuring that the requirements of participation are met and that the procedures established by the Program are carried out. Paramedical staff performing screening examinations and tests shall be trained and their services limited to their area of competence and in accordance with the professional. practice acts governing the health disciplines.

2. The screening package shall include, but not be limited to, the following basic screening services for eligible recipients as appropriate for age and health history and in accordance with acceptable standards for preventive health care in children.

   a. Health and developmental history
   b. Unclothed physical examination
   c. Developmental assessment
   d. Vision and hearing testing
   e. Assessment of immunization status and updating immunization
   f. Assessment of nutritional status
   g. Laboratory procedures
      (1) Hemoglobin or hematocrit
      (2) Sickle cell*
      (3) Urinalysis
      (4) Tuberculin skin test
      (5) Lead*
      (6) Serology for syphilis and/or*
      (7) Culture for Gonorrhea

   *When Medically Indicated

3. Screening providers will be reimbursed for the screening services outlined above, and as appropriate for age and health history, rendered to eligible Title XIX clients as soon as they are declared eligible for Medicaid, and at the following ages:

02-04 weeks	16-19 months	07-08 years
02-03 months	23-25 months	09-10 years
05-06 months	3 years	11-12 years
09-10 months	4 years	13-14 years
12-15 months	5 years	15-16 years
	6 years	17 through 20 years

4. The clinic shall maintain a medical record for each recipient screened with all entries kept current, dated, and signed. The record shall include, but is not limited to, the following:

a. Patient history
b. Physical assessment findings
c. Growth and development records
d. Disposition of patient
e. Name of referral source (name of physician, dentist, etc.)
f. Record of immunization
g. Copy of agency reporting forms
h. Copy of referral form

5. All clinic records of recipients are to be completed promptly and are to be systematically filed and retained for 5 years.

a. The clinic shall have policies to provide for the systematic retention and safekeeping of recipients' medical records for the required period of time in the event that the clinic discontinues operation.

b. If the recipient moves to an area outside the clinic's service area, written permission of the parent or guardian shall be obtained so that a copy of the'recipient's medical records can, and shall be, transferred to the clinic providing service in that area.

c. Screening providers receiving requests for release of EPSDT findings to Boards of Education and/or Head Start Programs are directed to:

(1) Establish an agreement with the appropriate-school superintendent and/or head start official to safeguard confidential information. A copy must be retained in the clinic's files (see appendix). Individualized agreements to safeguard confidential information are not required but the agreement would cover all persons within the category living in the school district.

(2) Obtain written authorization for the release of EPSDT findings to school superintendents and/or head start official from the parent and/or legal guardian (see appendix).

(3) Prior to releasing EPSDT findings, individual screening records must be marked "confidential information."

6. The clinic shall have the necessary equipment, in proper working order, to provide the basic screening tests outlined herein.

The area utilized during the testing period of the EPSDT exam shall provide adequate privacy and a minimum of interference to assure maximum accuracy from the test.

7. The clinic shall make available for review and audit by authorized representatives of the KMAP at all reasonable times the medical, administrative, and financial records pertaining to services rendered to Program recipients.

Representatives of the Program will conduct (1) surveys to determine compliance with Federal, State and local regulations, and (2) fiscal audits to determine cost of care.

8. The KMAP recognizes that cases of suspected child abuse and neglect may be uncovered in regular Early and Periodic Screening Program examinations. If such cases are discovered, an oral report shall be made immediately by telephone or otherwise to a representative of the local Department for Social Services office. Within 48 hours a report in writing shall be made to the local Department for Social Services office for use in investigation and appropriate action to protect the child involved.

   To facilitate reporting of suspected child abuse and neglect cases, legislation effecting the reporting of child abuse, (KRS 199.335) is printed on the reverse of Cabinet for Human Resources Child Abuse Reporting Forms.

9. Basic Services

   The following tests and assessment procedures may be used in evaluating the health status of the Program recipient. The procedures outlined are suggested testing procedures; however, approved equivalent procedures may be used to obtain the desired results. The "Standards for Preventive Health Care in Children" is to be used as a reference manual.

   a. Medical History

      A medical history will be obtained from the parent or guardian by qualified personnel and retained in the recipient's medical record. A consent form shall be signed by the parent, guardian, or responsible person authorizing the provider to perform the basic screening tests, update the immunizations, and to share pertinent information with any state agency providing service or supervising services to the recipient.

      The health service provider's professional staff (R.N., A.R.N.P., or M.D.) is responsible for obtaining the medical history. If this responsibility has been delegated by the professional to a trained paraprofessional, 'the professional must review the findings with the parent and/or legal guardian at the time of the physical assessment examination.

The parent and/or legal guardian has authority to give written consent for the EPSDT service. The Department for Social Services will in some instances be the legal guardian for an eligible Medicaid recipient and therefore will have authority to give the required written consent for EPSDT services. It should be noted, however that the Department for Social Services only has this authority for those cases committed by the courts to their care, i.e. foster care children.

b. Procedures and Tests

The following procedures and tests shall be performed in accordance with acceptable standards for preventive health care in children, as appropriate for age and health history.

(1) All recipients of screening services shall have their height and weight recorded and their growth percentile measured using a standard chart. Development shall be assessed by health history, physical findings, appraisal of the significant milestones of the maturation process, and utilization of standard growth and development charts.

Standard growth charts constructed by the National Center for Health Statistics in collaboration with the Center for Disease Control may be secured by request from the Department for Medicaid Services.

(2) A blood pressure shall be taken on eligible recipients over 35 months of age and/or on all recipients of screening services when indicated.

(3) A routine throat inspection shall be done on each recipient by the examining physician, nurse, or nurse practitioner.

(4) A routine dental inspection shall be carried out. Some of the children, 3 years of age and above, may have accepted the dental component of EPSDT and been referred at intake by outreach staff to the dentist for diagnosis and treatment.

(5) All eligible recipients are to be checked for obvious physical defects such as hernia, orthopedic, skin, eye, etc. If any abnormality is detected, diagnosis and treatment or a referral shall be initiated.

(6) A complete or dip stick urinalysis (blood, sugar, ketone bodies, and protein) shall be done on each recipient as appropriate for age and health history. Bacteriuria screening shall be done for the at risk groups.

Supplies and forms for Bacteriuria screening can be obtained by writing:

Kidney Screening Program
Department for Health Services
Division of Preventive Services
275 East Main Street
Frankfort, Kentucky 40621

(7) Visual screening shall be carried out using the appropriate Snellen Chart and/or equivalent tool. Screening results in recipients too young to utilize the standard equipment may be obtained by other means such as observation, object identification, etc.

(8) All recipients should be checked for evidence of ear disease such as obvious infection, foreign bodies, wax impacted canal, drainage, or other abnormalities. At the age of 47 months and up an audiometric evaluation should be performed.

(9) A hematocrit or hemoglobin shall be done on each eligible recipient as appropriate for age and health history.

(10) When medically indicated, all eligible recipients who are at high risk for sickle cell anemia shall be offered screening for sickle cell anemia either on-site or by referral.

(11) Tuberculin Skin Tests shall be performed on eligible recipients who are at risk for developing tuberculosis.

NOTE: Since local and district health departments have the resources and are mandated to control tuberculosis, KMAP service providers should work with their local health departments to insure that all necessary medical, nursing and epidemiological follow-ups are provided to KMAP service recipients found to have infection or disease.

(12) An assessment of immunizations should be made and immunizations updated if necessary. Program payment doe's not include the cost of vaccines. The administration of the vaccine is included in the charge for the screening service.

NOTE: Information regarding immunizations and vaccines may be obtained by contacting:

The Department for Health Services
Division of Local Health
Communicable Disease arid Prevention Section
275 East Main Street
Frankfort, Kentucky 40621

(13) Serology for syphillis and/or a culture for gonorrhea shall be done when the history and nursing assessment indicate the necessity.

(14) Routine testing for lead poisoning shall not be required by the Program; however, in those cases where the physical symptoms or environmental conditions indicate possible lead poisoning, a referral should be made to the physician or to the appropriate medical service for follow-up. If referral is made for lead. poisoning, the block 14 on the MAP-7 should be completed.

10. Referrals:

At the end of the screening process abnormalities noted should be discussed in terms understandable and meaningful to the recipient, parent and/or guardian, and arrangements initiated or referrals made for diagnosis and treatment.

All referrals, either within the clinic or to other outside providers, shall follow the procedures listed for setting up diagnosis and treatment appointments.

a. Clients capable of and preferring to make their own appointments.

(1) Appropriate assistance is given the client by the screening provider.

(2) Note the screening finding on the Referral Form MAP-83 and give two (2) copies of the completed referral form to the client for presentation to the referral resources.

b. Clients unable to follow through with making appointments for diagnosis and treatment.

(1) The client's choice of referral resources is honored and appointments are made for diagnosis and treatment by the screening provider.

(2) Note the screening finding on the Referral Form MAP-83 and forward two (2) copies of the completed referral form to the referral resource.

c. The screening provider is to:

(1) Refer EPSDT participants'to Title V services when appropriate (See Directory of Title V Services)

(2) Assist clients with abnormality(ies) for which treatment is not covered by the State Title XIX plan in securing needed diagnosis and treatment services at little or no cost to the client.

d. The KMAP requires your help as a provider of screening services in the identification and referral of clients who may be eligible for Women, Infants and Children (WIC) Supplemental Food Program.

The WIC Program is designed to provide specific nutritional foods to pregnant women; breast-feeding women, up to one (1) year postpartum; or women to six (6) months postpartum, plus infants and children under five (5) years of age, who reside in an approved area and are determined to be at nutritional risk by a health professional.

In order for the local WIC Project to be made aware of these children, you are asked to utilize the Referral Form (CH-115) for any recipient screened whom you identify as potentially eligible for WIC benefits. The completed CH-115 form should then be forwarded to your local WIC Project.

The WIC Supplemental Food Program nutritional risk criteria and a list of local WIC Projects may be secured from the Department for Medicaid Services.

EPSDT ADDENDUM

Procedural Coding

Following EPSDT services, the invoice form (MAP-7) is to be completed in accordance.with the instructions in Section VI - Completion of the Invoice Form, with special attention directed to the services and tests listed in blocks **#11** and **#12.** The following coding should be entered in each box for each service and test listed:

CODE	ASSESSMENT
A	Normal
B	Abnormal Referred
C	Abnormal under treatment

If referrals have been made, designate in blocks **#14** and **#15.**

All EPSDT examinations will use procedure code **Y6000.**

PHARMACY ADDENDUM

Pharmacy

Pharmacy services must meet the standards of the pharmacy component of the KMAP. A pharmacy component of the Rural Health Clinic must hold an operation permit from the Board of Pharmacy in the state in which the Clinic is located.

1. Providers must maintain such records as are necessary to fully disclose the extent of the service provided, including the original prescription and its refills. The original prescription must be maintained in a numerical order prescription file. If computerized prescription records are maintained, adherence to the requirements of Kentucky Board of Pharmacy Regulation 201 KAR 2:170 is acceptable for prescriptions for which Kentucky Medical Assistance Program payment is requested and made. Records must be maintained as a prescription file independent of recipients' case records for a period of not less than five (5) years from date of service. Providers must furnish to the Division or its authorized representatives, as requested, information regarding any claims for pharmacy services rendered under the Medical Assistance Program.

2. Notification must be made to the KMAP regarding any change in the status of the pharmacy component.

3. The cost of covered drug items which are prescribed and certified to be required for eligible Program recipients by a duly-licensed physician, dentist, osteopath, or podiatrist will be allowed under conditions established in the Primary Care Principles of Reimbursement. "Duly-licensed physician, dentist, osteopath, or podiatrist" would refer to those individuals so licensed under the existing state regulations and statutes effective in the state wherein they practice.

4. In addition to standard drug pre-authorization, there are certain drugs which may be considered generally suitable for individuals in specific living circumstances and/or with a characteristic pattern of health needs (e.g. personal care home recipients). In these circumstances, groups of drugs may be pre-authorized for individuals upon appropriate request, with no individual pre-authorization numbers assigned for the drugs.

5. The Pharmacy Program uses several investigative and screening methods to detect any abuse on the part of the prescriber, pharmacy, or recipient. Computer print-outs are reviewed periodically (e.g., quarterly). Data is compared against norms of the specific medical service **area's** for number of prescriptions per recipient, cost per prescription, and cost per recipient. If the figures show significant deviations from the norms, the pharmacy is **flagged** for in-depth review. Records are more thoroughly examined and physician, pharmacy and recipient contacts are initiated to determine the cause for the unusual pattern of care. If inappropriate practices are found to be provider oriented, the case(s) is (are) referred to the respective Peer Review Committee for recommendations for Program action, which could include non-payment and/or suspension from the Program.

6. Advertising is not to be used to influence the free choice of a pharmacy by a recipient. Advertisements should convey only participation in the Program.

7. The Kentucky Medical Assistance Program Outpatient Drug List

   The KMAP Outpatient Drug List indicates the specific drugs which are covered by the Program. Limitation in available funds has necessitated the development of the Drug List. The Drug List is evaluated and revised in accordance with recommendations from prescribers and pharmacists who participate in the Program, in accordance with funds available, and in accordance with the interests and needs of Program recipients. Information obtained from consultation with the Formulary Subcommittee (an advisory committee appointed by the chairman of the Advisory Council for Medical Assistance), and with practitioner/staff associated with medical schools in the State is also utilized in accomplishing revisions to the Drug List.

8. Prescription Quantities

It is expected that prescribers will prescribe the quantities which ***most*** nearly fulfill the recipient's needs with due regard for economy and prevention of wastage. Quantities of medication dispensed must be the same as prescribed by the physician. The KMAP will not reimburse those prescriptions when quantities prescribed have been changed by the pharmacy without approval by the physician. This policy will be monitored through post payment review.

Prescriptions should be filled for the exact quantity ordered by the prescriber. If a change in **quantity is made,** the prescriber must approve of the change and properly document it in the patient's record and include the following information:

a. the authbrized changed quantity amount
b. the reason for the change
c. certification that the pharmacist contacted the prescriber and requested the change which the prescriber then authorized
d. the name of the pharmacist requesting the change
e. the date of authorization for quantity change

Also, the **harmacist** must properly document the change in quantity ~~either on the~~ Rx itself or on an attached document and include the following information:

a. the authorized changed quantity amount
b. the reason for the change
c. certification that the prescriber has been contacted and concurred with the change
d. the name of the prescriber and name of any office worker who transmitted authorization on behalf of the prescriber
e. date of **authorization** for quantity change
f. name of pharmacist receiving authorization and filling the prescription
g. prescription number involving quantity change

Program coverage will not be allowed for duplicate prescriptions - i.e. more than one prescription for a drug listed under the same reference number (generic category) and dispensed to the same recipient by the same pharmacy on the same day.

9. Prescriptions: New and Refills of Originals

Prescribers must properly document (either in the patient's chart or in the Refill Log as the case may be) all Rx's prescribed by them for Medicaid patients and include the following information:

a. drug name
b. strength and dosage of drug
c. quantity
d. refill limits
e. days supply
f. instructions for taking medicine

Prescriptions covered under the KMAP Outpatient Drug List and through the Pre-Authorization Program cannot be refilled more than five (5) times or more than six (6) months (180 days) from the date of the original -prescription. Once a prescription has reached this stage, a new prescription must be authorized and signed by the prescriber in accordance with provisions in **#13.** Prescription Authorization and a new prescription number must be assigned.

When listing refills on the billing statement, the original prescription number should be entered. Only the date of service would differ from the information pertaining to the original prescription.

Prescriptions bearing refill instructions should be refilled at appropriate intervals as shown by the dosage schedule on the prescription for the specific drug.

PRESCRIPTION REFILL NOTATIONS - State regulations require that the pharmacist record refills of all prescription-legend drugs by writing the date of the refill together with his/her name or initials on the back of the original prescription. The date of the refill may be stamped on the prescription if the pharmacist so desires.

In instances where the KMAP has been billed for- prescription refills for which no documentation exists in the dispensing pharmacy's records the charge will be disallowed or a refund must be made by the dispensing pharmacy to the Kentucky State Treasurer in the amount of Program payment for unauthorized refills.

If computerized prescription records are maintained, adherence to the requirements of Kentucky Board of Pharmacy Regulation 201 KAR 2:170 is acceptable for prescriptions for which Kentucky Medical Assistance Program payment is requested and made.

10. Legal Requirements

Current Federal and State regulations will pertain in all instances where the KMAP requirements do not specify a more stringent policy.

11. Product Standards

Standards for quality, safety, and effectiveness of drugs for which the KMAP makes payment shall be those set forth in the United States Pharmacbpeia or National Formulary, where applicable, in any directives issued by the Food and Drug Administration, where applicable, and in any state or federal regulations, where applicable.

12. Prescription Substitution

Except as provided by Kentucky's Drug Product Selection ("Generic Drug") Law, specified or express permission, approval, or consent of the prescriber is required before a pharmacist may substitute any other drug, medicine, chemical, or pharmaceutical preparation.

If such approval or consent is obtained from the prescriber, the brand name or the name of the manufacturer of the drug, medicine, chemical, or pharmaceutical preparation dispensed must be written on the prescription by the pharmacist.

13. Prescription Authorization

A supervising physician must sign all prescriptions prescribed by an intern working under his/her direct supervision in a medical teaching institution.

Practitioner authorization, i.e. actual signature of the prescriber shall be required on all prescriptions not phoned in, on all Schedule II controlled substance prescriptions, and when the physician override (certification of brand name necessity) procedure is being used. For telephone prescriptions (but not including the preceding) the pharmacist shall enter on the prescription form the name of the prescriber and the initials of the pharmacist. Since the date and signature of the pharmacist must appear on all oral prescriptions for Schedule III, IV, and V controlled substances, additional initialing by the pharmacist is not required.

14. Outpatient Drug List

The Outpatient Drug List is provided as a publication 'separate from this manual. Changes to this list are mailed on a monthly basis.

15. Additions To Outpatient Drug List

Drug products conforming exactly in active ingredient content to the respective generic name on the Drug List can be added to the KMAP Outpatient Drug List when requested by prescribers and pharmacists who participate directly (i.e. either prescribe drugs for or dispense prescriptions to KMAP recipients) in the KMAP, if the following conditions are met:

a. The name, address, telephone number, prescriber license number or KMAP primary care number, of the individual initiating the request must be provided.

b. The requested drug product must have an "effective" or "probably effective" FDA rating.

c. A copy of the notification of New Drug Application (NDA) or Abbreviated New Drug Application (ANDA) approval from the Bureau of Drugs and/or Office of New Drug Evaluation, National Center for Drugs and Biologics, Food and Drug Administration (FDA), Rockville, Maryland, must be provided, or the requested drug product must be included as an approved drug in the current edition of the FDA publication, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations." (Note: This requirement will not apply to products marketed originally prior to 1938.)

d. Complete information regarding the requested drug product must be provided and certified to the KMAP. This includes: generic name, product name, manufacturer name, distributor name (if different), National Drug Code Number, package size, cost to pharmacy of most frequently purchased packaged size, strength and dosage form, listing of all active ingredients together with respective strength of each ingredient. (Note: Forms for the submission of this required information are available from the KMAP, upon request.)

Also, if a requested product falls within a multiple source group which includes products deemed to be therapeutically equivalent by the Food and Drug Administration (FDA) and so designated by an "A" code in the FDA publication referenced in c. above, the requested product also must have an "A" code in order to be added to the KMAP Outpatient Drug List.

e. The requested drug product must conform exactly in active ingredient content to the respective generic entity.

16. Drug Pre-Authorization

The Pharmacy Program includes a drug pre-authorization procedure which supplements the KMAP Outpatient Drug List. Some medications, which are not on the Drug List and which are essential for a recipient to avoid hospitalization or higher levels of care, may be made available through this procedure. Physician consultants and agency employed nurses review each request and make determinations on the basis of Program criteria.

Certain criteria must be met before the drug is approved. (See Appendix.) If the requested drug is approved, the recipient's choice of pharmacy is contacted to determine whether the pharmacy will provide the approved drug.

The original authorization is valid for a time'determined on an individual basis - provided the recipient remains eligible and the need for the drug-continues to exist.

Information regarding pre-authorization may be obtained by calling toll free 1-800-372-2986.

17. Lock-In

a. Utilization Review:

Utilization review of recipient participation patterns occasionally demonstrates exceptional and excessive use of Program benefits. Recipients in this category may be placed in lock-in status which limits their physician and pharmacy benefits.

The recipient will remain on the Lock-In Program until the utilization profiles indicate a normal utilization pattern for the'recipient's condition. Lock-in limitations only apply to physician and pharmacy services, and do not preclude needed emergency services or referral.

b. Identification of Lock-In Recipients:

Lock-In recipients are identified by a special, pink Medical Assistance Identification Card. Each eligible member of a Lock-In family unit will be issued this special MAID Card monthly. The names of the recipient's Lock-In pharmacy and/or physician provider will be entered on the MAID card each month.

c. Pharmacy Profiling System

Each Lock-In recipient is entitled to Pharmacy services as prescribed by their Lock-In Physician. The number of prescriptions and days' supply are monitored by the selected Lock-In Pharmacist, by use of a profiling system.

Occasionally unique situations arise, which necessitate the dispensing of medication in a manner which deviates from the general guidelines of the Lock-In Program (i.e., more than 4 prescriptions per month). In these situations, the Pharmacist is encouraged to exercise his professional judgement in dispensing the medication(s). If a questionable case should arise, the Pharmacist is encouraged to contact the Lock-In Coordinator for verification of coverage.

The advantages of profiling systems have demonstrated an improved utilization of medication as well as a significant cost savings through a reduction of unnecessary prescriptions.

Program staff will conduct retrospective reviews of utilization patterns and any problems that are identified will be discussed with the Pharmacist.

d. Emergency Situations

If a recipient should request medications from a Pharmacist other than the Lock-In Pharmacist, careful inquiry should be made concern- reason (emergency - recipient out of town, Lock-In Pharmacist out of medication,' etc.) for the request.

If it is determined by the Pharmacist that a real emergency or unique, situation exists, the prescription should be dispensed and the Lock-In Coordinator notified by mail or phone, to assure reimbursement. See Page 4.13, Section IV, #8, Lock-In Recipients for further information.

18. Procedure Code

The procedure code to be billed for all prescriptions is 99199.

I. Clinical Pharmacist's Services

Clinical pharmacist's services, provided by a licensed pharmacist on the staff of the Rural Health Clinic, include obtaining and recording recipient medication histories, monitoring drug use, contributing to drug therapy, drug selection, counseling, administering drug program, and surveillance for adverse reactions, and drug interactions.

Individual clinical pharmacist service counseling rendered eligible recipients is a cost-allowed service and shall be documented in the patient's records. Services may be reported on the year-end cost report as a cost of the clinic's total cost, but can not be billed on the MAP-7.

DENTAL ADDENDUM - BENEFIT SCHEDULE

Services Covered

Dental services are limited to those procedures covered through the Dental Services element of the KMAP. If a service is not listed in the Dental Benefit Schedule, it i.s not payable by the Program. Limitations as to the number of times a procedure is payable in a l&month period are indicated by procedure. All services except those otherwise indicated are limited to recipients under age 21 (coverage for those turning 21 will continue through the end of their birth month).

A. Out-of-Hospital Services: Payment for services is limited to those procedures listed on the department's dental benefit schedule, and include benefits in the following categories:

1. Diagnostic
2. Preventive
3. Oral Surgery
4. Endodontics
5. Operative
6. Crown
7. Prosthetics
8. Orthodontics
9. Other Services

Out-of-Hospital refers to all locations where dental services are provided, except hospital admittance. For example:

Clinic
Hospital Outpatient Department
Dentist's Office
Nursing Home
Patient's Home

B. Out-of-Office Services: Considered to be locations where the dentist must travel away from his usual office to render professional services. For example:

Nursing Home
Patient's Home
Hospital Outpatient Department

Services listed on the Dental Benefit Schedule are applicable when rendered in out-of-office locations.

C. In-Hospital Services: Refer to dental services rendered a patient admitted to a hospital overnight.

Reimbursement for inpatient dental procedures will be made to both general dentists and oral surgeons. (See Page 11 of the Dental Addendum for a listing of procedure codes.)

A general dentist may submit a claim for hospital inpatient service for the patient termed "medically high risk." Medically high risk is defined as a patient with one of the following diagnoses:

Heart Disease
Respiratory Disease
Chronic Bleeder
Uncontrollable Patient - retardate or emotionally disturbed
Other - automobile accident, high temperature, massive infection

All non-emergency hospital admissions must be pre-authorized by PEERVIEW.

To obtain prior authorization, a responsible person in the rural health clinic's office must contact the Peerview office at 1-800-423-6512, for a pre-admission review of proposed elective admissions. A pre-authorization code will be given to the rural health clinic's office by Peerview, indicating approval for the admission. A person in the rural health clinic's office must transmit that code to the hospital's admitting office at the time of the admission. This code allows the Peerview coordinator to certify the admission.-.-Kentucky hospitals will not be reimbursed by the KMAP for non-emergency admissions unless the admissions were pre-authorized and certified by Peerview.

DENTAL ADDENDUM - BENEFIT SCHEDULE

****
* DENTAL BENEFIT SCHEDULE *
****

Diagnostic Services (Available to all ages)

Procedure DO270 - Bitewing - Single Film

Procedure DO272 - Bitewing - Two Films

Procedure DO274 - Bitewing - Each Additional Film
Limit: A total of four (4) X-rays per patient, per 12 month period, per provider. Each of the above codes should be for one unit of service only.

Procedure DO220 - Intraoral - Periapical Single, First Film

Procedure DO230 - Intraoral - Periapical Each Additional Film
Limit: Fourteen (14) X-rays per patient, per 12 month period, per provider

Procedure DO330 - Panoramic - Maxilla and Mandible Film
Limit: One (1) per patient, per every twenty-four (24) month period, per dentist

NOTE: See Definitions of Dental Procedures

Preventive Services (Available to all ages)

Procedure D1110 - Prophylaxis - Adult (Excludes Fluoride)
Note: Adult is defined as age 21 and over

Procedure D1201 - Topical Application of Fluoride (Including Prophylaxis) Children
Note: Child is defined as 16 and under.

Procedure D1202 - Topical Application of Fluoride (Including Prophylaxis)
Note: Includes recipients age 17-20

Limit: One (1) per 12 month period, per patient

DENTAL ADDENDUM - BENEFIT SCHEDULE

Oral Surgery (Available to all ages)

Procedure D7110 - Extraction, Single Tooth
Limit: One per tooth, per patient

Procedure D7120 - Extraction, Each Additional Tooth
Limit: One per tooth, per patient

Procedure D7130 - Root Removal - Exposed Roots
Note: Root removal is not payable on same date of service to same tooth as the tooth's extraction.

Impactions

Procedure D7210 - Surgical removal of erupted tooth, requires elevation
Procedure D7220 - Impaction that requires incision of overlying soft tissue and removal of tooth
Procedure D7230 - Impaction that requires incision of overlying soft tissue, elevation of a flap, and either removal of bone and tooth or sectioning and removal of tooth
Procedure D7240 - Impaction that requires incision of overlying soft tissue, elevation of flap, removal of bone and sectioning of the tooth for removal
Procedure D7241 - Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances
Procedure D7250 - Root recovery (Surgical removal of residual root)
Procedure D7260 - Oroantral fistula closure (and/or antral root recovery)

NOTE: Extractions performed by general dentists in the outpatient department of the hospital are not reimbursable by the KMAP except in cases determined to be medically necessary and appropriate oral

surgical care is unavailable. Documentation will be required prior to any payment consideration. It would be necessary for the dentist to attach a letter of explanation to the claim form. This letter would need to include the diagnosis necessitating hospital care and also a statement that an oral surgeon was not available in the medical service area. This letter must be signed by the dentist; delegated signatures are not acceptable. When appropriate oral surgical care is available, recipients should be referred to a participating oral surgeon who can perform this service in his office.

When the patient has already been admitted to the outpatient department for other dental services, i.e., fillings, root canals, etc., in addition to the extractions, the provider can be reimbursed for the extractions. However, a letter signed by the dentist must be attached to the claim explaining the circumstances of the admission. Pedodontists are excluded from the requirements concerning outpatient department extractions. This policy is monitored through post-payment review.

Endodontic Services (Limited to recipients under age 21)

-Procedure D3110 - Pulp Cap - Direct (Excluding Final Restoration)
NOTE: Direct pulp cap is defined as the application of a pulp capping material such as calcium hydroxide placed directly on or in contact with the vital pulp tissue. Placement of the material over an area in close proximity of the cap but not actually in contact with the pulp chamber does not constitute a direct pulp cap.

Procedure 03220 - Vital Pulpotomy (Excludes Final Restoration)

Procedure D3310 - Root Canal Therapy, Anterior (Excludes Final Restoration)

Procedure D3320 - Root Canal Therapy, Premolar (Excludes Final Restoration)

Procedure D3330 - Root Canal Therapy, Molar (Excludes Final Restoration)

NOTE: The Sargenti method of root canal treatment is not covered under the present root canal procedure codes.

DENTAL ADDENDUM - BENEFIT SCHEDULE

When billing for root canal therapy, the procedure constitutes treatment of the entire tooth. It is not appropriate to perform a root canal on only one root of a molar and bill the KMAP for root canal therapy on a molar since that code represents treatment to the entire tooth. These are monitored through post-payment review.

Operative Services (Available to all ages)

Amalgam - Primary

Procedure D2110 - Amalgam - One Surface

Procedure D2120 - Amalgam - Two Surfaces

Procedure D2130 - Amalgam - Three Surfaces

Procedure D2131 - Amalgam - Four Surfaces

Amalgam - Permanent

Procedure D2140 - Amalgam - One Surface

Procedure D2150 - Amalgam - Two Surfaces

Procedure D2160 - Amalgam - Three Surfaces

Procedure D2161 - Amalgam - Four or More Surfaces

Composite Resin

Procedure D2310 - Acrylic or Plastic or Composite Resin

Procedure D2330 - Composite Resin - One Surface

Procedure D2331 - Composite Resin - Two Surfaces

Procedure D2332 - Composite Resin - Three Surfaces

Procedure D2335 - Acrylic or Plastic or Composite Resin (Involving Incisal Angle or Four or More Surfaces)
NOTE: This procedure code can not be billed in conjunction with any other operative service code or the procedure code for crowns performed on the same tooth on the same date of service. The use of mastiques is not allowed for this procedure code. Policy is monitored through post-payment review.

Limit: Acrylic, Plastic or Composite Resin Fillings (procedure codes D2310-D2335) are limited to anterior teeth only. Anterior teeth are defined as tooth numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27, C, D, E, F, G, H, M, N, 0, P, Q, and R.

NOTE: The KMAP recognizes five (5) surfaces of a tooth (buccal or labial, mesial, distal, lingual, occlussal or incisal). Any combination of the above procedure codes can be used for a total of 5 surfaces, per tooth, per provider, per date of service. This is monitored by both computer audits and post-payment review.

CROWN (Limited to recipients under age 21)

Procedure D2930 Prefabricated Stainless Steel - Primary Tooth

Procedure D2931 Prefabricated Stainless Steel - Permanent Tooth

Procedure D2932 Prefabricated Resin Crown
Limit: Anterior Teeth Only

NOTE: Should a provider choose to provide crowns for anterior teeth and/or permanent teeth, the usual and customary charge for a stainless crown must be billed. Since reimbursement for the tooth's restoration is included in the payment for the crown, this procedure cannot be billed in conjunction with any other operative service code for the same tooth number. This policy is reviewed by both system audits and post-payment review.

Prosthetic Services (Limited to recipients under age 21)

Procedure W0716 - Transitional appliance, includes one tooth on appliance, upper appliance
Limit: One per 12 month period, per patient

Procedure W0718 - Transitional appliance, includes one tooth on appliance, lower appliance
Limit: One per 12 month period, per patient

Procedure W0725 - Repair of fracture of transitional appliance and space maintainer
Limit: Three per 12 month period, per patient

Procedure W0726 - Repair of fracture and replacement of one broken tooth on a transitional appliance and space maintainer
Limit: Three per 12 month period, per patient

Procedure D5610 - Repair broken complete or partial denture - No teeth damage
Limit: Three per 12 month period, per patient

Procedure D5620 - Repair broken complete or partial denture - Replace one broken tooth
Limit: Three per 12 month period, per patient

Procedure D5640 - Replace broken tooth - per tooth

Procedure D5520 - Replace missing or broken teeth - Complete Dentures - No other repairs

Procedure D5750 - Reline upper complete denture (laboratory)
Limit: One per 12 month period, per denture, per patient

Procedure D5751 - Reline lower complete denture (laboratory)
Limit:: One per 12 month period, per denture, per patient

Note: The repair of the clasp on removable partial dentures and relining of removable partial dentures are not presently covered benefits.

DENTAL ADDENDUM - BENEFIT SCHEDULE

Orthodontic Services (Limited to recipients under age 21)

Limit: To any combination of the below procedures per 12 month period totaling. two, per patient

Procedure D1510 - Space maintainer, fixed unilateral type

Procedure D1515 - Space maintainer, fixed bilateral type

Procedure D1520 - Space maintainer, removable unilateral type

Procedure D1525 - Space maintainer, removable bilateral type

Procedure D8110 - Removable Appliance Therapy

Procedure D8120 - Fixed or cemented appliance therapy

Tooth numbers are no longer required for orthodontic services.

NOTE: See Definitions of Dental Procedures

Other Services

Procedure D9110 - Palliative (emergency) treatment of dental pain, minor procedures
Limit: One per date of service, per'recipient, per dentist

NOTE: Emergency Treatment refers to an actual dental treatment, necessary in an emergency situation, that is not covered by any other procedure on the Dental Benefit Schedule. Only one emergency may exist during any one visit, even though treatment may involve more than one procedure or tooth. It is necessary that both the diagnosis and the actual treatment rendered be entered on each claim form submitted for procedure D9110.

When the emergency treatment is a covered procedure, or a non-emergency, non-covered treatment, the emergency treatment procedure may not be billed. The following list represents unacceptable and therefore non-payable services for procedure D9110.

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* DEFINITIONS OF DENTAL PROCEDURES *
****

1. ORTHODONTIC SERVICES

(Procedures D1510, D1515, D1520, D1525, D8110, D8120) refers to an appliance necessary for the minor tooth movement or guidance of one or a few teeth. Payment applies to the appliance only. Diagnostic records and adjustment visits are presently outside the scope of covered benefits. Definitions of these procedures are as follows:

Fixed Space Maintainer

Definition: An appliance requiring cemented orthodontic bands with varying attachments such that patient removal or adjustment is difficult.

D1510 Fixed, Unilateral Type

Examples: a. Band and Loop
b. Cantilever type

D1515 Fixed, Bilateral Type

Examples: a. Soldered or adjustable lingual arch
b. Soldered or adjustable transpalatal arch
c. Cantilever type

Removable Space Maintainer

Definition: A space maintenance appliance which is readily removed by the dentist or the patient. The appliance may or may not have bands or stainless steel crowns.

Example: acrylic base appliance with or without clasps and/or teeth

01520 Removable, Unilateral type
D1525 Removable, Bilaterial type

NOTE: D1510, 01515, D1520 and D1525 are used for the maintenance of existing intertooth space.

D8110 Removable Appliance for Minor Tooth Guidance

Definition: An appliance, used for the positioning of one or a few teeth, that is readily removed by the dentist or patient.

Examples;
a. Hawley type with a variety of activating attachments
b. lip bumber with a variety of activating attachments
c. headgear with two molar bands and a facebow

D8120 Fixed or Cemented Appliance for Minor Tooth Guidance

Definition: An appliance requiring cemented orthodontic bands, with varying attachments for the positioning of one or a few teeth, such that patient removal or adjustment is difficult.

Examples:
a. diastema closing spring
b. adjustable lingual arch
c. adjustable transpalatal arch
d. crossbite correction (two bands and crossbite elastic)
e. segmented arch appliance (usually used for molar rotation and limited to one quadrant)
f. 2 X 4 or 2 X 6 appliance (involves two molars and four or six anteriors to correct anterior tooth rotation - limited to one arch)

VISITING NURSES SERVICES ADDENDUM

The nursing care covered by this section includes:

1. Services that must be performed by a registered nurse or licensed practical nurse if the safety of the patient is to be assured and the-, medically desired results achieved; and

2. Personal care services, to the extent covered under Medicare as home. health services. These services include helping the patient to bathe, to get in and out of bed, to exercise and to 'take medications.

Exclusions from coverage:

1. Household and housekeeping services.

2. Any service that would constitute custodial care.

Services Rendered by the Rural Health Clinic Visiting Nurses

Nursing Treatments/Procedures

Initial R.N. Evaluation
Adm. of Insulin Injection
Prep. of Insulin Syringes
Adm. of B12 or other B complex Injections
Adm of other IM/Subq Injections (Identify in block #19)
Adm. of IV's/Clysis
Adm. of I.P.P.B. Treatment/Oxygen/Postural Drainage/Deep Breathing
Decubitus Care
Wound Care/Dressings requiring Aseptic Technique;
Adm. of other special skin care (Identify in block #19)
Adm. of Hot Soaks/Hot Packs
Adm. of Colostomy/Ileostomy/Ileo-conduit care
Adm. of Gastrostomy Feeding
Gastrostomy Tube-Removal/Insertion
Adm. of Tracheostomy care
Catheter-Removal/Insertion
Foley Catheter Irrigation
Removal of Fecal Impact/ch. for fecal impaction
Enema (If condition necessitates skills of nurse)

VISITING NURSES SERVICES ADDENDUM

Nursing Treatments/Procedures (Continued)

Adm. of Eye medication/Post cataract care
Veni puncture for laboratory test (Identify test ordered in block #19)
Restorative Nursing (Exercises/Range of Motion/Gait Training/Transfer Technique/etc.)
Other Nursing Treatment/Procedure (Identify in block #19)
Skilled Observation (Inc. V.S./Med. Reaction/Edema)
Follow-up Evaluation for I.P.P.B. or Home Oxygen Therapy
Return visit on same day (Must enter in block #19 the medical reason for the return visit)

Instruction or Teaching Visits (Patient/Family/Neighbor)

Instruction in Establishment of a Bowel and Bladder Training Program
Instruction in Cast Care
Instruction in Catheter Care
Instruction in Colostomy/Ileostomy/Ileo-Conduit care
Instruction in Decubitus and/or Skin Care
Instructions regarding diabetes (Symptoms of Insulin Shock, etc./Diet/Foot Care/Skin Care)
Instruction in Diet or Nutritional Counseling
Instruction in Application of Dressing/Wound Care
Instruction in Administration of Injectable Drugs;
Instruction in Administration of Eye Medication and/or Dressing
Instruction in Gastrostomy Equipment Care/Feeding Preparation
Instruction in Administration of I.P.P.B. treatments/Oxygen/Deep Breathing Exercises/Postural Drainage
Instruction regarding medication-Review and Evaluation of Dosage/Tolerance/Untoward Side Effects/Refills
Instruction in Tracheostomy/Suctioning
Instruction in ROM Exercises/Transfer Technique/Ambulation
Instruction in care for terminally ill patient
Instruction in care of bedfast patient
Other teaching/instruction visit {identify in block #19)
Follow-up evaluation for assessing how family/patient is following instructions for patient care.

VISITING NURSES SERVICES ADDENDUM

Personal Services

Personal Care Services (Please identify in block #19 the description of services rendered i.e. bath, ambulation)
Performance of exercises as an extension of therapy program
Decubitus care
Dressing change
Enema
Catheter care and irrigation
Household services appropriate to health care in preventing institutionalization (i.e. cleaning patient's room, doing patient's laundry)
Retraining patient in self-help skills of activities of daily living
Assistance with medication